

Health Care Financing Grants and Contracts Report

Hospital Fraud Audit Manual

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Health Care Financing Grants and Contracts Reports

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TABLE OF CONTENTS

PART I - INTRODUCTION

		<u>Page No.</u>
Section 1	Purpose and Scope of the Manual	1
Section 1.1	Description of a Hospital	5
Section 1.2	Overview of Medicare and Medicaid	13
Section 1.3	Third-Party Payments System: An Overview	26
Section 1.4	Reimbursement: An Overview	26
Section 1.4.1	Statutory Basis of Reimbursement	26
Section 1.4.2	Sources of Regulation	29
Section 1.4.3	Impact of Third-Party Reimbursement	30
Section 1.4.4	New York State Medicaid and Blue Cross Reimbursement	31
Section 1.4.5	The Medicare System of Reimbursement	33
Section 1.5	Hospital Accounting	35
Section 1.6	Investigative Auditing	38

PART II - AUDITING TECHNIQUES

Section 2	Audit Objective and the Role of the Auditor	40
Section 2.1	Audit Objective	40
Section 2.1.1	Evidence, Communications	43
Section 2.1.2	Relationships with other Members of the Investigative Team	44

		<u>Page No.</u>
Section 2.2	Planning and Control of the Audit	45
Section 2.2.1	Preliminary Research and Target Selection	45
Section 2.2.2	Records to be Obtained and Reviewed	53
Section 2.2.3	Communications with Hospital Staff	55
Section 2.2.4	Beginning the Audit	57
Section 2.2.5	Audit Logistics	66
Section 2.2.6	Specialized Audit Techniques	67
Section 2.2.7	Internal Control Review	69
Section 2.2.7.1	Audit Approach to Reviewing Internal Controls	73
Section 2.2.7.2	Additional Pointers on Internal Control Review	75
Section 2.2.7.3	Internal Control Checklist	78
Section 2.2.8	Summary Outline of Typical Audit Approach	80

PART III - REIMBURSEMENT AUDIT GUIDES

Section 3.1	Audit Guide for the Review of Cost Reporting, Cost Finding, and Reimbursement Rate Setting	84
Section 3.1.1	Maximizing Reimbursement	86
Section 3.2	Examples of Fraudulent Practices	88
Section 3.3	Procedures for Auditing Cost Reports and Reimbursement Rate Setting	94
Section 3.4	The New York Experience	113

PART IV - EXPENDITURE CYCLE AUDIT GUIDES		Page <u>No.</u>
Section 4	Audit Guide for the Expenditure Cycle (Purchasing)	117
Section 4.1	Introduction to Purchasing	118
Section 4.1.1	Description of Purchasing Functions	118
Section 4.1.2	Audit Objectives	120
Section 4.1.3	Vendor Kickbacks	121
Section 4.1.4	Rebates, Discounts, and Allowances	123
Section 4.1.5	Expenses not Related to Patient Care	124
Section 4.1.6	Undisclosed Non-Arm's Length Relationships	125
Section 4.1.7	Employee Embezzlements	126
Section 4.1.8	Internal Control (Purchasing)	127
Section 4.1.8.1	Review of Internal Control and Procedures Relating to the Purchasing Function	127
Section 4.1.8.2	Review of Internal Control and Procedures Relating to the Receiving Function	130
Section 4.1.8.3	Review of Internal Control and Procedures Relating to Accounts (Vouchers) Payable	132
Section 4.1.8.4	Review of Internal Control and Procedures Relating to Cash Disbursements	134
Section 4.1.9	Audit Guides for Reviewing Transactions in the Expenditure Cycle (Purchases)	137
Section 4.1.9.1	Cash Disbursements	138

		<u>Page No.</u>
Section 4.1.9.2	Purchase Invoices	145
Section 4.1.9.3	Preparation of a Major Vendor List	150
Section 4.1.10	Tracing Findings to the Cost Report	153
Section 4.2	Vendor Audits	156
Section 4.2.1	Examples of Fraudulent Practices	159
Section 4.2.2	Auditing Procedures (Vendors)	161
Section 4.2.3	Concluding the Vendor Audit	166
Section 4.3	Audit Guide for Reviewing Transactions in the Expenditure Cycle - Payroll	167
Section 4.3.1	Internal Control - (Payroll)	169
Section 4.3.1.1	Internal Control - Examples of Sound Practices	170
Section 4.3.2	Procedures for Auditing Payroll	172
Section 4.3.3	Special Procedures for Auditing Payroll	176
Section 4.4	Audit Guide for Fiscal and Administrative Expense	180
Section 4.4.1	Examples of Fraudulent Practices (Fiscal and Administrative Services)	182
Section 4.4.2	Audit Procedures for Reviewing Fiscal and Administrative Expenses	183
Section 4.5	Audit Guide for Unassigned Expenses	186
Section 4.5.1	Depreciation and Amortization - Audit Objective	187
Section 4.5.1.1	Examples of Fraudulent Practices (Depreciation and Amortization)	188

		<u>Page No.</u>
Section 4.5.1.2	Procedures for Auditing Depreciation and Amortization	189
Section 4.5.2	Leases and Rentals	190
Section 4.5.2.1	Leases and Rentals (Audit Objective)	191
Section 4.5.2.2	Examples of Fraudulent Practices (Leases and Rentals)	192
Section 4.5.2.3	Procedures for Auditing Leases and Rentals	194
Section 4.5.3	Insurance	197
Section 4.5.3.1	Insurance (Audit Objective)	198
Section 4.5.3.2	Examples of Fraudulent Practices (Insurance)	199
Section 4.5.3.3	Procedures for Auditing Insurance	200
Section 4.5.4	License Fees and Taxes	202
Section 4.5.5	Interest Expense	203
Section 4.5.5.1	Examples of Fraudulent Practices (Interest Expense)	204
Section 4.5.5.2	Procedures for Auditing Interest Expense	205
Section 4.6	Employee Benefits	207
Section 4.6.1	Examples of Fraudulent Practices (Employee Benefits)	208
Section 4.6.2	Procedures for Auditing Employee Benefits	209

PART V - REVENUE CYCLE AUDIT GUIDES		Page No.
Section 5	Audit Guides for the Revenue Cycle	211
Section 5.1	Revenue Cycle - Audit Objectives	212
Section 5.2	Admissions	213
Section 5.2.1	Internal Control - Admissions	215
Section 5.2.2	Test of Charges	216
Section 5.2.3	Sample for the Test of Charges	219
Section 5.2.4	Test Documents (Test of Charges)	222
Section 5.2.5	Audit Procedures for Test of Charges	223
Section 5.3	Billing (Accounts Receivable)	228
Section 5.3.1	Internal Control (Billing)	231
Section 5.3.2	Examples of Fraudulent Practices (Billing)	233
Section 5.4	Cash Receipts	236
Section 5.4.1	Internal Control (Cash Receipts)	237
Section 5.5	Allowances - Contractual and Other	239
Section 5.5.1	Internal Control (Allowances - Contractual and Other)	241
Section 5.5.2	Examples of Fraudulent Practices (Allowances - Contractual and Other)	242
Section 5.6	Credit and Collections	243
Section 5.6.1	Internal Control (Credit and Collections)	244
Section 5.6.2	Examples of Fraudulent Practices (Credit and Collections)	245
Section 5.7	Audit Guide for Revenue Centers (Ancillary Services)	246
Section 5.7.1	Audit Guides for Radiology	248

		<u>Page No.</u>
Section 5.7.2	Examples of Fraudulent Practices (Radiology)	249
Section 5.7.3	Audit Procedures (Radiology Department) Preliminary Review	251
Section 5.7.4	Audit Procedures (Radiology Department Interviews with Key Personnel	253
Section 5.7.5	Detailed Audit Procedures - Radiology Department	256
Section 5.8.1	Audit Guides for Laboratory	258
Section 5.8.2	Examples of Fraudulent Practices (Laboratory)	259
Section 5.8.3	Audit Procedures (Laboratory) Preliminary Review	260
Section 5.8.4	Audit Procedures (Laboratory) Interviews with Key Personnel	262
Section 5.8.5	Detailed Audit Procedures (Laboratory Department)	265
Section 5.9	Examples of Fraudulent Practices in Other Revenue Centers	267
Section 5.9.1	Examples of Fraudulent Practices (Operating Room)	268
Section 5.9.2	Examples of Fraudulent Practices (Anesthesiology)	269
Section 5.9.3	Examples of Fraudulent Practices (Pharmacy)	270
Section 5.9.4	Examples of Fraudulent Practices (Electrocardiology)	271
Section 5.10	Audit Guide for Provider-Based Physicians	272

		<u>Page No.</u>
Section 5.10.1	Provider-Based Physician Financial Arrangements	274
Section 5.10.2	Audit Objective - Provider-Based Physician Financial Arrangements	275
Section 5.10.3	Procedures for Auditing Provider-Based Physicians	277

PART VI - AUDIT GUIDES FOR BALANCE SHEET ACCOUNTS

Section 6	Audit Guide for Property, Plant, and Equipment	279
Section 6.1	Internal Control (Property, Plant, and Equipment)	280
Section 6.1.1	Examples of Sound Internal Control (Property, Plant, and Equipment)	281
Section 6.1.2	Examples of Fraudulent Practices (Property, Plant, and Equipment)	283
Section 6.1.3	Audit Procedures (Property, Plant and Equipment)	285
Section 6.2	Audit Guide for Construction Costs	290
Section 6.2.1	Internal Control (Construction)	293
Section 6.2.2	Examples of Fraudulent Practices (Construction)	295
Section 6.2.3	Procedures for Auditing Construction Costs	297
Section 6.3	Audit Guide for Investments	301
Section 6.3.1	Internal Control (Investments)	302
Section 6.3.2	Examples of Fraudulent Practices (Investments)	303

		<u>Page No.</u>
Section 6.3.3	Procedures for Auditing Investments	304
Section 6.4	Audit Guide for Other Balance Sheet Accounts	306
Section 6.4.1	Cash on Hand and in Banks	307
Section 6.4.1.1	Internal Control (Cash)	308
Section 6.4.1.2	Examples of Fraudulent Practices (Cash)	311
Section 6.4.1.3	Procedures for Auditing Cash	312
Section 6.4.2	Inventories	314
Section 6.4.2.1	Internal Control (Inventories)	315
Section 6.4.2.2	Procedures for Auditing Inventories	317
Section 6.4.3	Other Assets	319
Section 6.4.4	Liabilities	320
Section 6.4.5	Fund Balances	322
Section 6.4.6	Restricted Funds	323
Section 6.4.6.1	Examples of Fraudulent Practices (Restricted Funds)	326
Section 6.4.6.2	Procedures for Auditing Restricted Funds	328

PART VII - AUDIT GUIDE FOR OPERATING STATISTICS		Page No.
Section 7	Overview	330
Section 7.1	Reimbursement Rate Setting Statistics	332
Section 7.1.1	Audit Objectives	332
Section 7.1.2	Internal Control	333
Section 7.1.3	Examples of Fraud and Abuse (Reimbursement Rate Setting Statistics)	334
Section 7.1.4	Audit Procedures (Reimbursement Rate Setting Statistics)	335
Section 7.2	Cost Finding Statistics	338
Section 7.2.1	Examples of Fraud and Abuse (Cost Finding Statistics)	339
Section 7.2.2	Audit Procedures (Cost Finding Statistics)	341
Section 7.3	Statistics for Informational Purposes	343

PART VIII - FINDINGS AND DOCUMENTATION

Section 8	Workpapers	344
Section 8.1	Evidence and Findings	355
Section 8.2	Testimony	360
<hr/>		
Vendor Background - Questionnaire		364
Glossary of Relevant Terms		367
Bibliography		394

PART I : INTRODUCTION

Section 1 - Purpose and Scope of the Manual

The purpose of this manual is to assist the investigative auditor to detect and investigate fraud in the hospital setting. It is assumed that users of this manual will have a college degree in accounting or its equivalent and some auditing experience. Hospital work experience would be helpful, but is not necessary. This manual should be sufficiently descriptive for use by those with little or no hospital work experience.

Each section contains an overview of the applicable subject area, a description of problems that may be encountered, and examples of types of fraudulent practices that have been found in those areas. Also included is a detailed audit guide relating to each subject area. These guides are not intended to be used literally. Each guide should be modified according to the overall objective of the particular investigation, as well as to respond to problems encountered in the field. The information set forth in this manual should be invaluable to the auditor in setting the overall scope of the audit and in creating and modifying specific programs.

Throughout this manual there are examples of actual fraudulent practices uncovered in fraud investigations. The description of these schemes has been included for several reasons. First, it is hoped that these illustrations will assist the users of this manual to identify and document similar practices. Second, knowledge of the significant schemes that have been encountered will assist the auditor with little or no investigative background to become oriented to the investigative auditing environment.

Frauds the auditor should be alerted to include:

(a) Institutional fraud-

(1) Inflation of reimbursable costs:

(A) Inclusion of costs not related to patient care,

(B) Inclusion of costs of a personal nature, benefiting an owner or employee, and

(C) Inflation of costs as a result of dealings with related parties.

(2) Failure to reduce expenses by proper allocation of income.

(3) Improper classification or allocation of revenue or expense.

(4) Filing claims which are inflated or improper, or double billing.

(5) Using inaccurate or inappropriate statistics for reimbursement rate calculations.

(b) Employee frauds, embezzlements, or other wrongful acts -

(1) Theft of incoming checks or cash,

(2) Theft of checks issued by the provider,

(3) Theft of services,

(4) Theft of inventory, or

(5) Receiving kickbacks.

(c) Payoffs to government officials to influence decisions and legislation affecting the hospital.

Finding fraud is only the first step in the endeavor. The auditor must understand how it was accomplished, document it with books, records and workpapers, and ascertain when, by whom and by whose order or under whose direction it was carried out. It is imperative that all documentation be gathered from all sources to verify the fraud and to establish who is responsible for the fraudulent acts. The auditor must make use of all available resources and tools, auditing knowledge and expertise, the work of the investigators and attorneys and other state agencies, as well as hospital and independent audit staff, banks, credit agencies, vendors, and any other sources that are indicated. The use of subpoenas (if available) to compel production of records should not be overlooked, and interviews and discussions with witnesses and others are an essential tool. Gathering information from many sources can lead to uncovering discrepancies that may lead to the finding of fraud.

The remaining sections in this Part contain brief descriptions of the organization of the hospital administrative and service structure, the Medicare/Medicaid legislation (emphasizing Medicaid), the third-party payments system, reimbursement, accounting, and investigative auditing.

Section 1.1 - Description of a Hospital:

Organization and Management

(a) Organization

A hospital can be described as an institution organized principally to provide medical care and services for the prevention, diagnosis and treatment of disease, pain, injury and other physical and mental conditions. Hospitals fall into three general categories with respect to sponsorship:

(1) Proprietary or investor-owned hospitals.

Proprietary hospitals are profit-oriented entities whose owners are interested in a return on their investment, usually in the form of periodic income.

(2) Voluntary hospitals. Voluntary hospitals are organized on a not-for-profit basis and comprise roughly one-half of the hospitals in the United States. Voluntary hospitals were originally organized for charitable purposes under the sponsorship of religious groups and other voluntary organizations and associations. The major medical center teaching and community hospitals are usually organized on a voluntary basis.

(3) Public hospitals. Public hospitals are creations of federal, state, and local governments and are supported in large part by tax revenues. These institutions may serve a specific geographic area, offer a special service, or serve a low-income population.

The services provided by hospitals vary widely due to several factors including the type of sponsorship and the community needs of the population the hospital serves. The cost of patient care at each hospital will also vary widely with such factors as the range of services provided, and the costs of land, depreciation, labor, food, laundry and linen, equipment, and maintenance and engineering.

Hospitals are also categorized according to bed size, length of patient stay, and specialized services, e.g., community, teaching, short-term (acute) care, long-term care (patients admitted for a stay of more than 30 days).

(b) Services

Hospital services are delivered on an inpatient or ambulatory service basis, that is, the patient is placed in a hospital bed for a stay on an inpatient basis, or is treated on an outpatient ambulatory basis. Ambulatory services include emergency, clinic, ambulance, and home

health services. There is a wide variety of medical and surgical specialties found in hospitals, such as urology, cardiology, pulmonary diseases, ophthalmology, neurology, obstetrics and gynecology, internal medicine, family services, and pediatrics. Routine care services include dietary, nursing, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made. Special care units, including coronary care and intensive care units, are also part of routine services. Ancillary services, which vary in availability, are services for which separate charges are customarily made, such as delivery room, maternity labor room services, operating room, recovery room, anesthesiology, laboratory, blood bank, and radiology, as well as physical, speech, and occupational therapy services.

The teaching hospital, as differentiated from the community hospital, has as a basic goal medical education, which involves the teaching of house staff (interns, residents and fellows). As such, the teaching hospital offers intensive patient care and extensive specialty, sub-specialty and ancillary services not ordinarily found in non-teaching institutions. In the teaching hospital, an outpatient clinic system is maintained not only to provide care to the community, but

also to offer house staff a teaching setting involving direct patient care. The clinics organized in specialty and sub-specialty areas are a phenomenon of medical education and are not ordinarily found in community hospitals or non-teaching facilities.

With the increasing emphasis on regionalization of services, there is an attempt by health planners at categorizing hospitals as primary, secondary, and tertiary facilities. The intent here is to ensure through planning that there is not a costly duplication of services and equipment in a single geographic area, at the same time ensuring that basic medical services are available. Basic medical care needs would be met at a primary care facility providing family care services. The secondary facility, such as the community hospital, would have an increased complement of services and equipment for medical care and surgery, but would not have the teaching and research components and intensity of services that characterize the tertiary care facility. The tertiary level of care would include a variety of specialties and sub-specialties not available at facilities providing lower levels of care. At this time, however, there is considerable overlapping among the different levels of care and kinds of facilities with respect to services provided to patients. Thus, for

example, patients who could be served in primary care family health centers are often treated in teaching hospitals.

(c) Administrative and Service Structure

The hospital administrative and service structure is generally organized along the following lines: patient care services which are usually supervised by a nurse and may include social services and discharge planning; "hotel-type" services such as dietary, housekeeping, laundry and linen services; fiscal and administrative management; and professional services which include services provided by the medical staff as well as ancillary services. Hotel-type services and financial management are usually within the hospital administrator's purview; professional services are the responsibility of the medical staff. Although the administrator generally has responsibility for operating ancillary service departments, ancillary services usually are directed by physicians. The administrative and service structure varies in part with hospital size, and the separate service structure components will also vary by category of hospital and range of services provided.

The governing board of a hospital may be called the "board of directors," "board of governors," "board of trustees," or other similar name. The number of persons serving on the governing board will vary with form of sponsorship and size of hospital, among other factors. The governing board of a voluntary hospital will usually include persons who are prominent in the civic and business affairs of the community the hospital serves. The board of a privately-owned proprietary institution will usually consist of persons who have an ownership interest in the hospital. The board of a publicly-owned proprietary hospital may include employees of the corporation, as well as "outside" directors, that is, persons who are not also corporate officers or employees.

The governing board is responsible for establishing hospital policy and for the overall management of the hospital. Although it may be charged with responsibility for everything that happens in the institution, the governing board does not usually play an active role in management and operations on a day-to-day basis. A large governing board will usually have an executive committee consisting of a small number of board members that functions as the whole board between regular meetings. Actions taken by the executive committee are usually reported to the whole board which approves or disapproves

those actions. A well-organized governing board may also have other committees, such as the patient care committee, long-range planning committee, finance committee, professional services committee, and buildings committee, to deal with specific areas of the hospital's management and operations. These committees should report to the executive committee, if there is one, and to the whole board.

The administrative structure of a hospital is usually under the direction of a person called the "administrator." The administrator may be known by another name, such as "executive director," "president," or "chief executive officer." The administrator is the agent of the governing board and is the person to whom the board delegates responsibility for the day-to-day operations of the hospital. The administrator may have one or more assistants who have responsibility or authority, or both, over specific areas of the hospital's operations (e.g., purchasing, maintenance).

The governing board also has responsibility for choosing the medical staff. The medical staff has its own internal administrative organization which varies from hospital to hospital. Medical services are usually divided into departments by physician specialties (e.g.,

medicine, surgery) each with its own chief. A hospital may also have a medical board made up of the chief of staff, heads of departments, and attending physicians with full hospital privileges in a specialty. The medical board may also have an executive committee and other ad hoc committees, as well as professional committees.

Section 1.2 - Overview of Medicare and Medicaid

In 1965, the Social Security Act was amended to include Title XVIII (42 U.S.C. §1395 et seq.) which established Medicare, a program of health insurance administered by the federal government. Medicare provides coverage to all persons 65 years of age and over regardless of income. Eligibility for Medicare benefits has since been broadened to include disabled persons and individuals suffering from end-stage renal disease. Since 1975, persons who have not made the required contributions to the Social Security system are nevertheless entitled to enroll in the program for a monthly premium.

Financed through the Social Security system, Medicare is composed of two interlocking parts: Part A, hospital insurance, and Part B, medical insurance. Part A is often termed "compulsory" health insurance as those who pay social security contributions during their working lifetimes cannot opt out of the program, although they can decline to accept its benefits. Part A helps to pay for medically necessary inpatient hospital care, post-hospital extended care services and post-hospital home health services. Part B is funded through monthly contributions made at the election of the insured upon becoming eligible (e.g., attaining age 65), and helps to

pay for medically necessary physicians' services, outpatient hospital services, outpatient physical therapy and speech pathology services, as well as some medical services and supplies not covered by Part A, and home health services not preceded by hospitalization. The Medicare program involves deductibles and co-insurance, that is, payments for hospital services furnished during any spell of illness are reduced by the applicable deductible and co-insurance amounts. Funds are administered for Part A by fiscal intermediaries and for Part B by insurance carriers.

In the same legislative package with Title XVIII, Congress enacted Title XIX, Medicaid (42 U.S.C. §1396 et seq.). Medicaid is premised on public assistance to the needy with a concept of medical indigency built in. Medicaid is, therefore, available to persons meeting income eligibility requirements, including those eligible for public assistance and those whose medical expenses result in their spending down to a level of medical indigence. In general, Medicaid pays for hospital and medical services for persons too poor to pay for them.

Medicaid is state and locally administered with at least one-half the costs assumed by the federal government, and the remainder split between the state and local governments. Rates for services provided by institutions and facilities are established at the state level. Program eligibility requirements and types and amounts of services provided vary from state to state. Some states cover only the "categorically needy" and others provide coverage as well for the "medically needy" who must spend down to a certain income level in order to receive benefits. In general, the "categorically needy" are persons who are receiving public assistance, because they are poor and are either aged, blind, disabled, or specified members of families with dependent children; the "medically needy" are persons who could qualify for public assistance except for their slightly greater income or resources, but lack sufficient income or resources to pay all their medical bills.

Administratively, Title XIX (Medicaid) required each state to submit a state plan for medical assistance to the Department of Health, Education, and Welfare ("HEW"). Each state had to designate a single state agency to administer the plan and to meet other requirements. Having met the requirements for eligibility and services, among other things, and having produced a document

describing the program in detail, the state can obtain a substantial subsidy from the federal government for its Medicaid program. The minimum federal contribution for medical assistance expenditures to a state's approved Medicaid program is 50%, with a maximum of 83%, based on a complicated formula under which the federal contribution varies inversely with the per capita income of the state, that is, the federal government pays more to the state with the lowest per capita income. The federal government will also pay 75% of the administrative costs attributable to skilled professional medical personnel and 50% of other administrative costs in the state. Federal payments are made by HEW based upon quarterly estimates furnished by the state.

Under Title XIX (Medicaid), all categorically needy persons covered by a state plan must be provided with five basic services: (1) inpatient hospital services (other than in an institution for tuberculosis or mental diseases); (2) outpatient hospital services; (3) laboratory and X-ray services; (4) skilled nursing home services for persons aged 21 and older (other than in an institution for tuberculosis or mental diseases); (5) and physicians' services when rendered in hospital, office, or elsewhere. If the state plan includes the medically

needy, at least the following items of medical and remedial care and services must be provided to these persons: either the five basic services described above, or any seven of sixteen services (the five basic ones plus these eleven enumerated services): (1) medical or remedial care or services other than physicians' services, (2) home health services, (3) private duty nursing services, (4) outpatient clinic services, (5) dental services, (6) physical and occupational therapy, and treatment of speech, hearing and language disorders, (7) prescribed drugs, dentures, prosthetic devices, and eyeglasses, (8) diagnostic, screening, preventive and rehabilitative services other than those for which provision is made elsewhere in the regulations, (9) inpatient hospital, skilled nursing facility and intermediate care facility services for persons 65 and over in an institution for tuberculosis or mental diseases, (10) intermediate care facility services other than in an institution for tuberculosis or mental diseases, and (11) inpatient psychiatric services for persons under age 21. The seven optional services may include one or more of the five basic services.

Title XIX (Medicaid) did not allow the states to require any cost sharing (enrollment fee, premium, or similar charge, or deductible, co-insurance, co-payment) with

recipients for mandatory care and services provided to categorically needy recipients. States can impose a deductible, co-insurance, or co-payment on the categorically needy for services other than the five mandatory services, and on the medically needy for any service under the state plan, with limitations on the amounts chargeable to recipients. Since 1974, individual states that provide benefits to the medically needy have the option to impose an income-related enrollment fee, premium or similar charge on that class of recipients.

Medicaid is a system of vendor payments, that is, the provider (e.g., hospital, physician, laboratory) files a claim for payment with the state or local agency which pays the provider directly or through a fiscal agent. In some states, the recipient of services does not have to sign or file a claim form. Payments to hospitals for inpatient care are to be on the basis of "reasonable cost," a phrase to be interpreted according to standards approved by the Secretary of HEW. "Reasonable cost" bears a direct relationship to the actual cost of services provided. As costs increase, so does reimbursement. Methods of reimbursing other providers of health care were left unspecified. States can, therefore, choose their own reimbursement formula for other than in-hospital services provided under Medicaid

and set their own payments schedules, including following the Medicare formula, that is, paying physicians and other eligible professionals their customary charges.

Medicare can be characterized as a highly structured federal program with defined conditions and criteria for eligibility and types of services to be provided, while Medicaid can be characterized as an open-ended program allowing for state discretion. Despite eligibility for Medicare or Medicaid, the patient may nevertheless remain with limited services or coverage. For example, the deductible and co-insurance features of Medicare are a practical limitation on its availability to lower-income elderly patients because they cannot afford to share costs or purchase supplementary insurance. It is possible, however, under federal-state "buy-in" agreements for states to enroll and pay premiums of Part B eligibles receiving public assistance. Further, the failure of the physicians to accept assignment for Medicare patients, that is, to accept the Medicare determined reimbursement rate in full payment for services, has often resulted in patients having to pay substantial additional expenses. With respect to Medicaid, the low levels of reimbursement have discouraged physicians from delivering services to Medicaid patients in their private offices. Thus, many

Medicaid eligibles with limited access to care are forced to use hospital emergency rooms or outpatient departments for primary care.

The Medicare and Medicaid programs are subject to continuous analysis by a variety of governmental units, provider organizations, consumer groups, and other interested parties attempting to define ways to improve and facilitate delivery of health care. With rising costs of health care, consumer needs for service, and problems in delivery of service, the regulations governing these programs are constantly reviewed and changed. It is important to remain current regarding changes which affect all aspects of these programs, including eligibility, coverage, delivery of service and reimbursement, as these changes are critical to any investigation of possible fraud.

Section 1.3 - Third-Party Payments System:

An Overview

Health care is a growth industry, but because of the unique characteristics of the marketplace, it is also a highly inflationary segment of the economy. These characteristics include: the dominant role of third-party payments which distorts normal supply-demand interaction and operates to exempt expenditures for hospital care and physicians' services from the constraints of a competitive market; the absence of incentives for physicians and hospital administrators to be cost-effective in seeking or providing hospital services; and patient and physician desire for sophisticated and expensive treatment and equipment without apparent concern for cost-effectiveness or duplication of services. Physicians' fees and expenditures for physicians' services have been, and continue to be a principal cause of inflation of health care costs. According to "A Study of Physicians' Fees" by the Council on Wage and Price Stability (March 1978), over the 1950-1976 period, "60% of the increase in physician care costs is attributable to increases in prices, with the remainder reflecting increases in quantity of physicians' services purchased." (Id., Ch. I, p. 1.)

The principal sources of hospital revenues are third-party payments--Medicare, Medicaid, Blue Cross, commercial insurance, worker's compensation, and no-fault--which account for more than 90% of the direct and indirect payments to hospitals for services provided.

Medicare reimburses hospitals on a retrospective cost basis, that is, a hospital submits a cost report after the close of its fiscal year on the basis of which the hospital is reimbursed for allowable reasonable costs incurred during the year. The cost report and the related statistical data (e.g., patient days, number and types of services) purport to be a complete and accurate analysis of patient care costs and the number and types of services delivered. The importance of the cost report and accompanying statistical data in the rate setting process makes its preparation a major concern to the hospital, and it is absolutely essential that they be examined in detail in a fraud investigation.

Since 1974, Medicare reimbursement has been made on the basis of the lower of the provider's customary charges or reasonable costs. Since actual costs cannot be determined until the end of the hospital's cost reporting period, the fiscal intermediary must establish a basis for interim payments to each provider. An interim rate

of reimbursement can be computed and interim payments approximating actual costs will be made for services throughout the year, with final settlement at the end of the accounting period on the basis of actual (rather than estimated) costs, after audit of the hospital's records and agreement between the hospital and the fiscal intermediary as to total allowable reimbursable costs. There is a mechanism for accelerated payments in cases where the provider is experiencing financial difficulties or delays in submitting bills. The regulations also provide for a periodic interim payment method of reimbursement for Part A hospital and skilled nursing facility inpatient services and Part B home health agency services; under this method, bi-weekly payments approximating costs will be made. Cost reports can be filed with HEW directly or, as is more common, with the fiscal intermediary which is the conduit for payments to hospitals by Medicare and is also responsible for reviewing fiscal and other records of the provider to make sure that the hospital has an adequate ongoing system for furnishing the records needed to provide accurate cost data and other information capable of verification and audit and adequate for cost reporting purposes.

The basis of reimbursement in Medicaid programs is of two general types: reasonable cost, the same as Medicare with certain modifications; or the establishment of payment rates under any alternative method, but no higher than the reimbursement that would be calculated under Medicare. The Medicaid regulations provide that, if another third-party (including Medicare) has an obligation to pay for health care and services rendered to a Medicaid recipient, the provider is supposed to seek reimbursement from the other third-party.

Blue Cross is a third--and perhaps the largest--principal source of direct third-party payments to hospitals. Although Blue Cross plans vary widely with respect to the basis for payments (some are based on costs, others on charges, and others pay on the basis of negotiated prospective rates), Blue Cross plans generally provide for direct payments to hospitals in full settlement of their subscribers' (insured patients') bills. Blue Cross plans throughout the country have agreements with participating hospitals under which payments on behalf of subscribers are made directly to the hospital.

Commercial insurance coverage is another source of third-party payments to hospitals. There are two principal kinds of insurance coverage. An insurer may pay a

hospital directly for part or all of covered charges, or the insurer may indemnify the insured for a fixed amount of covered hospital charges.

It should be noted that the Blue Cross Association and a number of commercial insurance carriers act as fiscal intermediaries for Medicare Part A coverage. The Blue Cross Association, as the prime contractor, subcontracts the intermediary role to local Blue Cross plans and provides them with interpretations of the Medicare reimbursement regulations. It should also be noted that Medicare Part B coverage is administered by Blue Shield and other commercial insurance carriers. A state Medicaid program may provide all or part of its medical care and services through a fiscal agent which will process and pay vendor claims on behalf of the state Medicaid program, if the state does not handle claims itself.

Section 1.4 - Reimbursement: An Overview

Section 1.4.1 - Statutory Basis of Reimbursement

The HEW publication Your Medicare Handbook describes Medicare hospital insurance-Part A as insurance that helps to pay for three kinds of care: inpatient hospital care, and skilled nursing facility and home health care when medically necessary after a hospital stay. Part A covers the reasonable cost of inpatient hospital services, less deductible and co-insurance amounts which the beneficiary must pay. Medicare medical insurance (Part B) can be described as helping to pay for other health services (e.g., doctors' services, outpatient hospital care) not covered by Medicare hospital insurance (Part A). (Thus, for example, a Medicare patient who is X-rayed by the staff radiologist could have that service covered by both Part A and Part B: Part A for the hospital's cost of the X-ray procedure, Part B for the professional (physician) component.) Medicare is a federal government program administered by the Health Care Financing Administration ("HCFA") of the U.S. Department of Health, Education, and Welfare.

As noted in Section 1.2, Medicaid, which is partially funded by the federal government, is a state and locally administered medical assistance program covering hospital and other health services. Except for the services mandated for "categorically needy" persons, there is variation from state to state in covered services. It is necessary for the auditor to determine what services to Medicaid recipients are covered under the state plan. This information is obtainable from the state agency administering the plan.

Medicare Part A (hospital insurance) is reimbursed on the basis of "reasonable cost" which is defined in Section 1861(v)(1)(A) of the Social Security Act (42 U.S.C. § 1395x) as follows:

"The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services [to Medicare beneficiaries], and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included...."

Payment for inpatient hospital services under Medicaid is on the basis of:

***reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards consistent with section 1122 [of Title XI of the Social Security Act, 42 U.S.C. § 1320a-1], which shall be developed by the State and reviewed and approved by the

Secretary...except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII...." Section 1902(a)(13) of the Social Security Act, 42 U.S.C. 1396a(a)(13).

Thus, the basis of reimbursement under Medicaid is of two general types: (1) reasonable cost, the same as Medicare with certain modifications; or (2) the establishment of payment rates under any alternative method, but no higher than the reimbursement that would be calculated under Medicare.

The principles controlling hospital reimbursement are found in federal, state, and local laws as well as insurance carrier contracts. Each state and local government promulgates and passes those regulations and codes considered necessary to define hospitals and hospital services, and each state with a Medicaid program determines within certain limits (see Sec. 1.1) what coverage will be provided to Medicaid recipients. The auditor will be required to know the applicable federal, state, and local regulations. In addition, insurance carrier contracts should be understood as to their reimbursement impact.

Section 1.4.2 - Sources of Regulation

The principal sources of regulations controlling Medicare reimbursement are:

(a) Health Insurance Regulations - HIRM-1 (Code of Federal Regulations, Title 20, Chapter III, Part 405, Federal Health Insurance for the Aged.) This manual is based on Social Security Act, Title XVIII. These regulations have the force and effect of law.

(b) Health Insurance Manuals - (HIM-10 Hospital Manual and HIM-15 Provider Reimbursement Manual). The HIMs contain information and procedural material needed to assist in the administration of the Medicare program. Although these manuals do not have the same effect as the regulations (HIRM-1), they are official interpretations of the regulations.

(c) Commerce Clearing House (CCH) - Medicare and Medicaid Guide. This is not an official publication; it is, however, a valuable research tool because it contains interpretations of HIRM-1 and the various HIMs. In addition, court cases and rulings are summarized. Recent cases and developments in the law are reported in this publication in a timely manner.

Section 1.4.3 - Impact of Third-Party Reimbursement

Few patients pay hospitals directly for services rendered. Payment is usually made by the federal or state government or a health insurance carrier such as Blue Cross. Because these payments are so large a portion of hospital revenue, these major third parties are, in effect, providing financing to the industry. The regulations and principles controlling hospital reimbursement have had a tremendous effect on budgetary, staffing, expansion and service delivery decisions of hospitals. The long-term trend is a reduction of non-reimbursable services and an expansion of reimbursable services.

Each year hospitals file cost reports to establish Medicare reimbursement. These reports may also be used by other third-party payors, including Medicaid and Blue Cross, for rate setting purposes.

Section 1.4.4 - New York State Medicaid and Blue Cross
Reimbursement

In New York State, hospitals file a cost report (Uniform Financial Report) with separate supplementary information for Medicare, Medicaid, and Blue Cross. In New York, Medicaid and Blue Cross are subject to State regulations and reimburse based on a per diem or per visit rate, depending on whether the patient is an inpatient or an outpatient. These rates are determined by grouping general ledger accounts into cost centers identified on the Uniform Financial Report. Costs are then reclassified (shifted) to cost centers that more accurately reflect actual costs. Operating revenue not directly associated with patient care is then used to recover (reduce) expenses to reflect net costs.

Now the cost finding process begins. Costs of non-revenue departments are allocated to ancillaries, routine patient services, and non-reimbursable departments based on appropriate statistics. The process is essentially similar for Medicare, Medicaid and Blue Cross up to this point. Then, for Medicaid and Blue Cross, the accumulated ancillary department costs are allocated to routine patient services and non-reimbursable cost centers based on statistics or charges. Finally, a per

diem or per visit rate is determined by dividing the final allocated cost (net of grant, research or gift income related to operating expenses) by the relevant statistic (days or visits). In New York State, the rates are modified by trend factors (consumer price index or other factors) for inflation; these rates are the basis of reimbursement to hospitals for services provided two years after the cost year. Since the rate of reimbursement is determined before a fiscal period has begun, this method of reimbursement is "prospective."

Section 1.4.5 - The Medicare System of Reimbursement

Hospitals receive a tentative or interim rate from Medicare based on past experience which is used for interim reimbursement of services to program participants. At year end, the facility files its annual cost report (HCFA-2552 or other approved form) with the Medicare fiscal intermediary. Based on the cost report, the fiscal intermediary calculates the total reimbursement by computing for each hospital routine and ancillary service department the percentage of utilization by Medicare patients. For example, the ratio of Medicare patient days to all patient days is determined for purposes of segregating inpatient costs. For ancillaries, the ratio of Medicare charges to all charges is computed. The ratios are then applied to allowable costs developed in the cost finding (stepdown) process to determine the percentage of Medicare's portion of departmental costs. Thus, the formulas are:

Routine Inpatient Cost:

$$\frac{\text{Medicare Patient Days}}{\text{Total Patient Days}} \times \text{Routine Inpatient Stepdown Costs} = \text{Medicare Cost}$$

Ancillary Service Departments:

$$\frac{\text{Charges to Medicare Patients}}{\text{Charges to All Patients}} \times \text{Ancillary Department Stepdown Costs} = \text{Medicare Cost}$$

The total of the departments' Medicare costs are then compared to the total interim reimbursement and a settlement is made between the hospital and the fiscal intermediary pending a final audit. The Medicare reimbursement system is "retrospective" because the rate of reimbursement for a fiscal period is determined after the close of that fiscal period.

Section 1.5 - Hospital Accounting

Hospitals have been described as businesses insofar as they are subject to the same principles of business management as any commercial venture. There is a difference, however, as a majority of hospitals are organized on a not-for-profit (voluntary) basis and purportedly do not operate for the gain or profit of any one individual or group. Consequently, they receive freedom from taxation; also, they are able to attract charitable donations which can be tax deductible.

Different accounting systems have evolved for voluntary, proprietary, and public hospitals. Investor-owned facilities use accounting systems which follow general concepts and accounting principles for business enterprises. These systems have been influenced or modified to reflect the structure of the organization and its functions, as well as third-party reimbursement requirements. Not-for-profit hospitals, on the other hand, since they do not represent ownership by any individual or group of individuals, have developed a system of accounting called fund accounting. "Fund Balance" on a voluntary's balance sheet is the equivalent of "Owner's Equity" or "Capital" on a proprietary's balance sheet.

Fund accounting seeks to segregate, by means of independent self-balancing accounts (funds), all resources (assets minus liabilities) by their purpose. This is because not-for-profit hospitals obtain funds largely from donors and others who often place restrictions on their use by the hospital. Each not-for-profit hospital, therefore, will have an unrestricted fund and any number of restricted funds. The unrestricted fund represents all resources available to the governing board for the general operation of the hospital. The operating accounts, including all revenue and expenses relating to the general operation of the hospital, are included here. Restricted resources, including related revenue and expenses, are recorded in separate restricted accounts. The disposition of these funds must be in accordance with the conditions imposed by the donor or grantor. Interfund transactions between unrestricted and restricted funds and among restricted funds themselves must be monitored to ascertain whether they are proper and in accordance with the terms of the restriction imposed by the donor, grantor or other party in an arm's length transaction, and do not violate the integrity of the fund.

In all other respects, there are no significant differences between generally accepted accounting

principles for commercial enterprises and fund accounting principles for hospitals.

Auditors examining public hospitals must obtain an understanding of the governmental or municipal accounting principles utilized by these facilities.

Section 1.6 - Investigative Auditing

Investigative or forensic auditing is an essential tool in uncovering fraud and other white-collar crime. Criminal prosecution of complex financial crimes is impossible without such audits and the testimony of investigative auditors. The functions of the investigative auditor employed in a state Medicaid Fraud Control Unit are to examine and interpret the books and records of health facilities, interview witnesses, prepare evidence for grand and petit juries and to testify before such juries.

Since fraud is generally based upon deception or misrepresentation, the primary task of the investigative auditor is to detect and document the fraudulent practice. The approach and procedures employed for this purpose are drawn from other types of auditing--financial, compliance and operations auditing--but must be extended and modified in each particular situation depending on the problem encountered and to be resolved. In essence, the investigative audit consists of two steps. First, the identification by targeting methods of areas of probable fraud. Second, in-depth auditing of these areas, utilizing every lawful means available to detect and document fraudulent practices.

In addition to possessing technical knowledge of auditing and the hospital industry, the successful investigative auditor must be open-minded and inquisitive while at the same time exercising a healthy skepticism. The auditor must also use common sense, be persistent and, most important, creative and resourceful.

PART II : AUDITING TECHNIQUES

Section 2 - Audit Objective and the Role of the Auditor

Section 2.1 - Audit Objective

Medicare and Medicaid frauds which can be uncovered by auditing techniques are committed by misstating the financial and statistical data, omitting to state material information used in determining reimbursement, and falsifying billings. The objective of the audits to be conducted by an investigative auditor is to detect and document fraudulent, manipulative, and deceptive practices in the hospital setting. The fact that this objective is different from the objectives of the internal auditor, the independent auditor, the fiscal intermediary, and other parties which audit hospitals should always be kept in mind. Auditors new to fraud investigations must constantly remind themselves of the fact that audit procedures used in routine financial or compliance audits are usually insufficient to uncover fraud and almost always have to be modified to be effective. Novel and extended procedures must be developed to assist the investigative auditor to probe into areas that are beyond the scope of compliance and financial audits.

It must be emphasized that the fraud audit is addressed primarily to those items that impact on the hospital's reimbursement by third-party payors, or that pertain to billings to third-party payors. The investigative auditor must, therefore, be familiar with the organization of the hospital's service structure, delivery system, and professional staffing, the regulatory standards controlling reimbursement, as well as billing procedures and rate setting. The auditor must take an approach significantly different from that of the independent certified public accountant whose basic objective is to determine whether or not the financial position of the entity is fairly presented in accordance with generally accepted accounting principles applied in a manner consistent with prior years. Routine auditing procedures, such as confirming cash in banks and accounts receivable balances, counting securities held as investments, and other functions primarily related to verification of balance sheet items, should not have to be done by the investigative auditor. This does not mean that the auditor should not ascertain that balances in accounts are accurately reflected in the books of account, for any inaccuracies can be the result of fraudulent transactions. The auditor has to determine whether the books and records can be relied on by whatever tests are necessary, but the tasks are reduced

by the work done in prior audits conducted by the independent auditors and fiscal intermediary as reflected in their workpapers and the review of internal controls.

The investigative auditor may observe many items such as underutilized equipment, excess personnel, and other situations which may be evidence of waste, incompetence, inefficiency, or negligence, but not necessarily fraud. Before pursuing an item to any great extent, the fraud auditor should consider carefully the probability that the item is indeed fraudulent. Items as to which no crime can be charged may nevertheless provide the basis for civil recovery or adjustments to reimbursement rates.

Section 2.1.1 - Evidence, Communications

It is not enough for the auditor simply to 'flag' a fraud situation. The auditor must plan at the very beginning to document the audit procedures and findings, and to obtain evidentiary materials such as contracts, invoices, checks, and other documents in support of findings in order to aid any resulting criminal prosecution and civil recovery action.

Communications, both oral and written, are very important to the success of the audit. The auditor must take care to communicate articulately with other members of the investigative team, with assistants, and with other interested parties, so that the results of the auditing efforts can be readily grasped and appraised. Care should be taken that facts are presented as facts and theories as theories and that they are clearly distinguished. Audit memoranda which discuss and explain the mechanics of the accounting process and the findings in relation to a specific scheme should be developed in the course of the examination. Early consideration to final report writing is essential.

Section 2.1.2 - Relationships with Other Members
of the Investigative Team

It must be remembered that the auditor may be only one of a number of specialists assigned to the investigative unit. The auditor's area of expertise is addressed to the accounting and financial records of the entity and encompasses the cost reports and the rate formulation as well. The unit should plan the assignment collectively with emphasis on coordination of efforts. Regular meetings of the investigative unit should be held to discuss progress and findings, to assign specific tasks, and to exchange information. To make the meetings productive, progress notes, copies of documents, interview synopses, and working papers should be prepared and distributed in advance.

Section 2.2 - Planning and Control of the Audit

Section 2.2.1 - Preliminary Research and Target Selection

(a) Target Selection. Target selection is the process whereby the investigative unit determines which facility is to be selected for audit and which areas of the facility's operations are to be reviewed or examined in depth. The investigative auditor must be involved at this stage and should contribute valuable insights based on prior experience and a review of the cost reports and related documents of the hospital under discussion.

Target selection is an ongoing process. It must be refined and updated as a result of experience gained and information obtained in the investigation. The mode of selecting targets may be one or a combination of the following:

(1) Allegations. Allegations or complaints received from outside sources should be checked for accuracy. Significant allegations should result in a decision to investigate the hospital at least on a limited basis.

(2) Leads. Leads developed through liaison with other public bodies or investigative units often result from communications with, and interviews of personnel of these organizations. The auditor should take part in these discussions and review whatever materials, files, or documents are obtained. Examples of some of the types of sources involved are: state health departments, local health systems agencies, fiscal intermediaries, the local professional standards review organization ("PSRO"), insurance companies, and consumer complaint bureaus.

(3) On-Site Surveys. On-site surveys of hospitals operating in a particular locale or having similar characteristics involves visiting and touring the institutions. An operations or management audit type of survey utilizing questionnaires, checklists, interviews of key personnel, and observations of actual conditions should be performed. Based on the information obtained and additional research work as described in subsequent parts of this section, a decision whether to continue the investigation should be made. The auditor, of course, should be a member of the survey team.

(4) Statistical Comparisons. Statistical comparisons can be a useful tool in pinpointing targets. This method entails the gathering of annual cost reports from providers in the group being tested. The methodology could be developed as follows:

(A) The following comparisons can be done to target hospitals:

(i) A breakdown of all hotel-type costs reflecting a cost per unit (e.g., cost per meal, by salaries, other than salaries, and total cost).

(ii) A breakdown of all service and ancillary costs on a unit basis (e.g., radiology -cost per procedure, by salary, other than salary, and total cost).

(iii) A summary of the results of each statistical analysis by type of cost and year for each hospital in the group; relative rankings are then assigned to each hospital by year. Based on the relative rank, patterns of variation and other data, hospitals and specific operating areas within hospitals can then be selected for audit.

(B) The following comparisons can be made to target departments within hospitals:

(i) Annual comparisons of all significant hospital statistics reported for a particular facility on a year-by-year basis (e.g., number of beds, patient days, occupancy rate, emergency room visits, outpatient visits). Any variances may require explanation.

(ii) Comparisons of a hospital's year-by-year operating results from the statement of revenues and expenses. Again, any variances within a hospital are to be noted for further investigation.

(5) Prior Investigations. Data obtained from prior investigations should be placed in the agency's central files and cross-indexed by provider, vendor, and other pertinent details. An example of how this would aid target selection is: a vendor was found to be giving kickbacks at one institution; the vendor's relationship to a second institution might be turned up by examining the second facility's vendor list and information in the central file index of the investigative unit.

(b) Cost Reports. The cost reports submitted by the hospital are the primary sources of information used in the rate setting process. Determining the validity of the data in the cost reports is a primary purpose of the audit. In preparing for the audit, the auditor should obtain copies of all cost reports and supplementary statistical and other information filed or submitted with the cost report. Copies of any appeals filed by the hospital and determinations of those appeals should be obtained. The examination of the supporting documentation for these appeals and any other documents used in rate setting should be part of the auditor's preliminary review. In order to avoid the possibilities of error or deception, the documents referred to above should be obtained directly from the agency with which they were filed.

(c) Planning the Scope of the Audit. The initial planning of any audit should be based on the results of the target selection process. Throughout the investigation, the auditor should always keep in mind the reasons why a particular hospital was selected for audit, but the scope of the audit should not be limited only to the areas initially selected. The auditor should always be alert to other potential problem areas and should modify the scope of the audit as necessary as the investigation progresses.

Any audit performed must be guided by the principles of practicality. Hospitals are complex fiscal and service organizations. Some are quite large, having many services and clinics available for patient care, such as inpatient, intensive care, maternity, pediatric, nursery, psychiatric, emergency, specialized clinics, and ancillary services. In addition, hospitals often engage in activities that are not directly related to patient care, such as research, education, and shared services. To audit these institutions completely may be impracticable. Although in a full-scope audit a review of all major areas of operations should be made, the auditor could not hope to do a 100 percent review in all these areas. Extended audit procedures should be applied to those areas where an initial review shows a weakness, or where there is reason to believe a fraud exists. The audit should include a thorough analysis of all significant audit exceptions noted by the auditor. In other areas, where there is no reason to suspect a problem, either the audit should be quite limited, or no audit at all should be done.

The investigative auditor is in a position to view the hospital from a vantage point not available to other auditors. Through subpoena (if necessary), the auditor can obtain access to the workpapers and reports of the

independent certified public accountant, so that it can be established whether the hospital has complied with generally accepted accounting principles and whether the hospital records accurately reflect its financial position and the results of its operations. Findings and reports of other governmental agencies reviewing hospitals are also available. Third-party payors' records are obtainable to help ascertain if the hospital has complied with their regulations, and other sources of information (e.g., the local PSRO, local health systems agency, consumer groups) are also available, so that the auditor is in a unique position to view the hospital from both inside and out. Judgments based on information developed from these reviews can be made as to the scope of the audit.

The auditor should not overlook the fact that many findings can be made outside the hospital (e.g., the review of a vendor's records can uncover a kickback scheme). If the need exists, banks can provide copies of checks or other documentation that cannot be obtained directly. Third-party payors may be able to supply printouts of payments to hospitals, clinics and hospital-based physicians, together with claim forms and checks paid; they can program their data banks to give a variety of information. As an example, in one county, the

Medicaid fiscal agent prepared a listing of all payments made on behalf of Medicaid patients where Medicare and insurance carriers were primarily liable; in some cases a hospital received multiple payments for services and failed to return excess payments to Medicaid and other third-party payors.

Prior to visiting the facility, the auditor should attempt to learn as much as possible about the hospital to aid in determining the scope of the audit. This requires an in-depth review of all records and documents about the hospital that the auditor can gather prior to the initial visit. By this prior review, the auditor will have the opportunity to compare costs for a period of years, and target those areas that appear to be out of line. This may also highlight those areas of weak internal control and other areas that should be reviewed in greater detail. Through these reviews, the auditor can also determine whether any ceilings on the hospital's rates have been imposed. If the hospital's costs are substantially in excess of its ceilings, the auditors should be aware from the outset that their findings may not result in an adjustment to the hospital's third party reimbursement rates.

Section 2.2.2 - Records to be Obtained and Reviewed

The records to be reviewed during the target selection process and prior to visiting the hospital are:

(a) Central files of the Medicaid Fraud Control Unit and the state agency charged with administration of the Medicaid program.

(b) Hospital questionnaire (see Investigative Manual, Appendix A) and the resulting computer profile, if available.

(c) The cost reports prepared and submitted by the hospital.

(d) Any supplements to the cost reports.

(e) Step-down calculations.

(f) Settlement sheets.

(g) Intermediary's:

- (1) Audit reports,
- (2) Management letters,
- (3) Workpapers,
- (4) Desk reviews,

- (5) Rate files,
- (6) Appeals,
- (7) Ceiling disallowances,
- (8) Permanent file, and
- (9) Correspondence files.

Copies of pertinent documents noted during this review should be included in the workpapers.

Section 2.2.3 - Communications with Hospital Staff

After reviewing the records listed in §2.2.2, arrangements should be made for a visit to the hospital and a tour of the facility. The tour will familiarize the auditor with the physical layout of the hospital, provide the opportunities to meet department heads, and make the auditor familiar with the location of records, files, and with the liaison for the hospital.

When an audit is agreed to by a facility, a confirming letter should be sent to the facility noting the date on which the audit will commence, the audit period involved, and the records which should be made available. The personnel assigned to the case should make arrangements with hospital officials to have the necessary books and records available for the auditors at the outset of the engagement. If this is not done, much time and effort can be wasted at the beginning of an investigation, particularly if hospital personnel want to stall the audit. Many stalling techniques can and will be used, such as: records purportedly misplaced, lost or stolen; records stored off-premises; or the employee responsible for records is on vacation or otherwise inaccessible to the auditor. Such situations, whether intentional or not, can waste days or even weeks. It is the

responsibility of the auditor to notify the attorney on the case immediately if any part of the agreement is not adhered to, so that a subpoena may be issued, or other appropriate action taken.

Section 2.2.4 - Beginning the Audit

(a) The group making the first visit to the facility should include the auditor in charge, the investigator, and the attorney assigned to the case. Discussions with provider officials should cover:

(1) Introductions to fiscal officers and other officials,

(2) Setting ground rules for working with facility personnel,

(3) Settling potential legal problems before they arise,

(4) Tour of facility, and

(5) Obtaining access to the hospital's independent auditor's files, including:

- (A) Workpapers,
- (B) Financial reports,
- (C) Management letters,
- (D) Permanent file, and
- (E) Correspondence files.

(b) Prior to starting the audit, the auditor should survey as many of the following as possible:

(1) Obtain organization chart for each period being audited, preferably one that is filled in with the names of individuals. It is important to establish responsibility, accountability, and chain of command.

(2) Discuss governance of hospital:

(A) Learn who the members of the governing board are, how they are appointed, their addresses and occupations,

(B) Inquire about any contracts with board members, such as land deals or construction,

(C) Request minutes of meetings of all boards for period being examined,

(D) Inquire about funds controlled by the board, board designated funds, and identify all segregated funds,

(E) Determine the extent of actual involvement by the board in management and day-to-day operations, and

(F) Inquire about background and qualifications of the administrative staff.

(3) Ascertain existing committees and their functions, both administrative and medical; identify chairperson and members of each committee; if possible, obtain minutes and memoranda of the committees. (The tissue committee reports are of particular importance because they contain information on unnecessary surgery.)

(4) Obtain operations manuals of each department and review them thoroughly. Most hospitals have operations manuals since these are required by the Joint Committee on Accreditation of Hospitals. This is particularly important with respect to areas such as purchasing, laboratory, pharmacy and surgery because the manuals will contain information about policies and procedures.

(5) Obtain all management letters and accounting reports.

(6) Identify any contracts (oral or written) between the hospital and its personnel and obtain copies of contracts, or documentation evidencing the agreement.

(7) Inquire into ancillary areas such as pathology, radiology, anesthesiology, pharmacy, and therapy; ask about the financial arrangements of hospital-based physicians and the extent to which outside services are used.

(8) Inquire about the number, function, and compensation of all staff physicians.

(9) Inquire about how doctors' billings are done and who is responsible for collections.

(10) Inquire about the PSRO and utilization review committee - whether there has been any reduction of length of stay and surgical procedures.

(11) Inquire about current problems in the hospital from the administrator's point of view, the problems encountered and solved, and immediate and long-range goals.

(12) Determine whether any particular group or person dominates or controls the hospital. It is important to understand the relationships between the administration and medical staff, nurses and doctors, employees and management. Also inquire as to employee morale and turnover.

(13) Determine if any trends can be discerned; if Medicare/Medicaid populations have increased; clinics planned; expansion contemplated; maternity and pediatric cutbacks.

(14) Try to get an overall picture of the range of services provided by the hospital, whether it is general, medical-surgical, or specialty (e.g., psychiatric, cosmetic surgery). Inquire particularly about highly technological equipment, renal dialysis, physical therapy, psychiatry, burn centers, intensive care and coronary care units, ultra-sound, and nuclear medicine.

(15) Inquire about the hospital's procedures concerning medical records, particularly with respect to completion of discharge notes and recording of progress notes, how soon after examination they must be filled in, and whether -- and for how long -- changes in medical records can be made.

(16) Interview patient representatives or patient advocates who handle allegations of patient abuse.

(17) Determine if the hospital is making or losing money and why; which third-party payor is most equitable, which least.

(18) Affiliations between the hospital and other providers, nursing homes, extended care facilities, apartments, real estate holdings, laboratories, and vendors should be listed and investigated.

(19) Inquire about such perquisites as bonuses, annuities, insurance, autos, living quarters, expense accounts, tuition aid.

(20) Inquire into the following specific areas:

(A) Accounts receivable and collections - how they are administered and by whom, which firms handle collections, percentage of bad debts, what amount is written off,

(B) Payroll - inquire about procedures for handling payroll,

(C) The emergency room - utilization and the extent to which it provides inpatients for the hospital,

(D) Ambulance services - if contracted, volunteer, or in-house,

(E) Pharmacy - whether floor stock or unit dosage system is used,

(F) Security - who provides it and how effective it is.

(21) Purchasing area. Determine by whom purchases are made; what policies are established; which departments do their own purchasing; whether the hospital utilizes purchasing cooperatives and its attitude towards them; inquire about bidding practices.

(22) Vendors. Inquire about who makes decisions to utilize certain vendors and the reasons for these decisions; review hospital's vendor list, if available, and inquire about vendors who have a large volume of business with the hospital, as well as those who have had a sudden recent increase in sales.

(23) Miscellaneous sources of income such as gift shop, parking lot, TV rentals, vending machines, rents, and grants should be examined.

(24) Construction projects. Inquire about planning, contractors and architects, affiliations with hospital (e.g., through governing board), and decision-making process.

(25) Tour of facility. Visit the following areas and note the general operation. Determine who is in charge and what record keeping is maintained:

- (A) Laboratories,
- (B) Intensive Care Unit (ICU), Coronary Care Unit (CCU),
- (C) Pharmacy,
- (D) Anesthesiology,
- (E) Radiology,
- (F) Physical therapy,
- (G) Dietary, including cafeteria,
- (H) Central supply,
- (I) Receiving,
- (J) Typical medical-surgical patient floor,
- (K) Emergency room,
- (L) Plant maintenance, and
- (M) Housekeeping.

(26) Inquire about off-site facilities, such as free standing clinics and community-based services.

Section 2.2.5 - Audit Logistics

When a field audit is conducted, the person in charge of the field work should set up lines of communication with the office to keep the other members of the investigative unit informed of all significant developments, and to keep the field audit staff current about the information and ideas generated by the other members of the investigative unit.

The auditor in charge of the field work should make a determination whether the telephone facilities at the field location are safe for confidential phone calls. If not, the auditor should use a pay telephone for sensitive calls.

While the audit is in progress, meetings should be held at least once every two weeks between all members of the investigative unit concerned with a particular case to discuss information, ideas, and the time budgeted for the audit. After completion of the audit, regular meetings should continue with other staff members until final disposition of the case.

Section 2.2.6 - Specialized Audit Techniques

If a questionable item of income, expense, or statistics has been found during the audit, it will be necessary for the auditor to trace the findings through the books of original entry to a cost report. The purpose of this step is to satisfy the auditor that the questionable item under review has found its way onto the cost report and subsequently was reimbursed by a third-party payor. The auditor may think a questionable item has been uncovered, only to find, for example, that it was charged to an owner's capital, draw, or other account and not reimbursed.

It should be noted that the hospital's independent auditors or the fiscal intermediary (or both) should have performed a tie-in of the adjusted year-end trial balance to the cost report. This is a requirement for certification by the accounting firm and is usually done during the preparation of the cost report. A copy of the tie-in should be made a part of the workpapers. Consideration should be given to an independent review if there was no prior review, or if the prior review was inadequate. An independent review must also be made if there is a finding that may result in a criminal prosecution or in a civil action for recovery of an

overpayment; in each case, the auditor must attest to its inclusion in the cost report in legal proceedings.

Some of the ways to start the tie-in process are account analysis, vendor analysis, or statistical analysis. Under any of the methods used, the first and most important step to perform is to obtain a clear understanding of the hospital's system of recording the type of item under review. Although the traditional method for tying-out such findings has been the account analysis approach, this method tends to require more work than may be necessary. Methods for tracing vendor findings are explained in Section 4.1.10 (on Expenditures); statistical tie-in is explained in Section 7.1.3 (on Statistics).

Once it is determined that the questionable item under review has found its way onto the cost report, it will be necessary to obtain assistance from the various third-party payors to determine whether the item has been reimbursed. It is important to know at this juncture whether ceiling cuts have been imposed in the rate setting process. A thorough review of ceiling disallowances should be made to ensure that the item did have an impact on reimbursement. A particular item may have been disallowed during an audit or desk review of the cost report and never reimbursed.

Section 2.2.7 - Internal Control Review

In the Statement on Auditing Standards Number 1 (SAS No. 1) promulgated by the American Institute of Certified Public Accountants, internal control is described as encompassing both administrative and accounting control. Administrative control is basically the plan of organization, the procedures, and the records leading to management's authorization of transactions. The authorization process is the key to achieving the organization's objectives. Accounting control flows from administrative control and comprises the plan of organization, the procedures and records necessary to the safeguarding of assets, the recording of transactions, and the reliability of financial records and reports.

The broad objectives of accounting control according to SAS No. 1 are to ensure that:

(a) Transactions are executed in accordance with management's general or specific authorization,

(b) Transactions are recorded as necessary to permit preparation of financial statements in conformity with generally accepted accounting principles or any other criteria applicable to such statements and to maintain accountability for assets,

(c) Access to assets is permitted only in accordance with management's authorization, and

(d) The recorded accountability for assets is compared with the existing assets at reasonable intervals and appropriate action is taken with respect to any differences.

The means employed to achieve the objectives of internal control are subdivided into systems and accounting controls. Systems are a series of tasks to be performed in order to recognize, measure, and record economic events. Accounting controls are techniques which can be built into a system, or are external to it, to ensure the integrity of the records and to safeguard the property of the hospital.

In a fraud audit, it is extremely important for the auditor to study and evaluate the hospital's internal control so as to gauge the degree to which fraud is likely to occur, where, and in what form.

The study and evaluation of a hospital in terms of controls must be divided into broad functional components so as to be manageable. These functions can be grouped into general financial planning and control, the

expenditure cycle, and the revenue cycle. Within each area there are distinct criteria and techniques to achieve the desired control objectives. The revenue and expenditure cycles and their respective control techniques will be discussed separately by function (see Parts IV and V). The procedures concerning the general financial planning and control functions are discussed in this section.

Before starting to review and evaluate internal control, the auditor should refer to the work done in this area by the hospital's internal auditor, independent auditor, and fiscal intermediary. Careful judgment should be made about whether -- and how much -- to place reliance on the work of other auditors. Certified public accountants are now required to communicate (not necessarily in writing) any material weakness in internal control to senior management. Copies of written communications and the workpapers in support of them can prove to be very useful in identifying target areas.

The role people play in the system cannot be minimized. People operate the controls and perform their tasks within each system. If staff members are poorly trained or unsupervised, the effectiveness of the system and the controls will be diminished. The auditor must realize

there are limitations in any system of internal accounting control. Personal failures or errors resulting from misunderstanding of instructions, mistakes in judgment, or lack of care can affect control procedures. Collusion at various levels of management may defeat control procedures which depend on segregation of duties. Unlawful acts by senior management, if detected, can lead to a lack of confidence in the control functions exercised by lower-level staff. Finally, the existence of controls in any period cannot be assumed to continue in future periods because of changes in conditions and personnel.

Section 2.2.7.1 - Audit Approach to Reviewing Internal Control

(a) A practical approach to the review of internal controls is to divide the procedures as follows:

- (1) Systems documentation - flow chart,
- (2) Evaluation of control techniques utilized,
- (3) Evaluation of relative risk, and
- (4) Compliance testing of transactions.

(b) There are certain control techniques that are basic to every organization and area. These can be varied and tailored to certain systems. Sound basic techniques include:

- (1) Segregation and rotation of duties so that one individual does not have complete control over the handling of transactions,
- (2) Periodic interchecking of control accounts to subsidiary ledgers,
- (3) Formal authorization requirements by supervisory level personnel together with review procedures,
- (4) Controlled use of prenumbered forms such as purchase orders, receiving reports, check requests, ancillary service orders, billing statements,

(5) Batch controls and verification of transactions,

(6) Clearly documented processing instructions,

(7) Exception reporting,

(8) Variance analysis of reported results,

(9) Internal auditing, and

(10) Competent personnel.

Section 2.2.7.2 - Additional Pointers on Internal
Control Review

The review should be performed on an interview basis. The person interviewed should describe the functions he or she performs. Do not ask questions that will elicit a simple 'yes' or 'no' answer. Although a questionnaire can be used, it should be used only as a guide to ensure that all important points are covered. It must be kept in mind that prior fiscal periods are being audited and, therefore, it will be necessary to obtain a description of the procedures that were in effect in those periods. The auditor must speak to the persons who performed the functions in prior years and, if they are no longer employed at the hospital, an interview with them may be necessary if the auditor is unable to determine from present hospital personnel what procedures were used in the past.

The interview should be with the persons who perform the functions. For example, if the auditor is discussing the purchasing function, it is necessary to speak to the purchasing agent, the accounts payable clerk, and any others who work in this area; the auditor should interview not only the controller or the administrator, because each will tend to give their perception of the

procedures. By interviewing the person who actually does the work, the auditor will obtain a more accurate picture of the controls being used. The interview should be on a one-to-one basis so that no one else can influence the response. For example, if the controller is present, the person being interviewed may say what he or she thinks the controller would like to hear.

The interview should be in the employee's work area preferably at the desk. This will tend to relax the person and keep the interview informal. The auditor should not criticize or berate the person, just have him or her describe the function as it is performed. The tone should be kept friendly and informal.

Copies of pertinent paperwork generated by the person being interviewed should be obtained. For example, in accounts receivable, blank billing forms, charge slips, and other documents should be obtained. The interviewer's notes and all documents obtained should present a complete and accurate picture of the operation of each area.

Each interview should be written up as soon as possible after its conclusion. All documentary material obtained should be properly exhibited with the narrative and

appropriately cross-referenced. Copies of all interview reports should be forwarded to the attorney and investigator assigned to the case. To facilitate a better understanding of the flow of data and paper in any area or between departments, flow charting should be used as a supplement to the narrative memorandum.

Again, bear in mind that the hospital's independent accountant may have reviewed the hospital's internal control and performed the appropriate compliance and substantive tests. The objective is not to duplicate work previously done, but to expand on those areas where weak internal controls appear to exist.

Section 2.2.7.3 - Internal Control Checklist -

General Financial Planning and Control
Functions

Note: "No" answers indicate potential weakness to be investigated further.

(a) Is an up-to-date complete organization chart available?

(b) Are record keeping (accounting) and custodial (treasury) functions separate?

(c) Is there a chief financial officer? Does this person report to the governing board?

(d) Is a chart of accounts in use? Is it adequate for the hospital's needs?

(e) Is an accounting manual used? Is it adequate for the hospital's needs?

(f) Are periodic reports of finances and operations prepared? Is it reviewed by the governing board? By department heads?

(g) Do department heads receive periodic statements of revenue and expense?

(h) Is a budget prepared? Is it used to control operations?

(i) Do department heads participate in budget review?

(j) Are all employees required to take annual leaves? Are duties reassigned?

(k) Is there a conflict of interest policy concerning employees accepting gifts from suppliers or acquiring financial interests in parties doing business with the hospital?

(l) Is there an internal auditor? Does this person report to the governing board?

(m) Are all journal entries and supporting documentation reviewed and approved by responsible officials.

Section 2.2.8 - Summary Outline of Typical Audit Approach

The following is a rational and systematic audit plan. This approach and the procedures specified throughout this manual should not be considered to be a rigid or inflexible plan, but rather should be modified or extended in light of circumstances (e.g., the presence of allegations, availability of records, and other developments that occur in the course of the investigation).

(a) Preliminary research and target selection
(done off-site):

- (1) Review of allegations,
- (2) Comparative analyses of detailed operating costs and statistics obtained from annual reports of reimbursable costs,
- (3) Review of results of hospital survey questionnaire,
- (4) Evaluation of the above and other factors.

(b) Initial on-site interviews.

(c) Evaluation of findings to date and determination of the scope of further audit/investigation.

(d) Overview process (done on-site):

(1) Review of investigative results to date.

(2) Review provider's cost reports, independent auditors' workpapers including management letters; fiscal intermediary's audit workpapers, statistics and comparative analyses.

(3) Review reimbursement and rate setting process (cost reports).

(4) Interview financial management.

(5) Review of board minutes and those of selected committees.

(6) Review of the hospital's operations:

(A) Completion of review of systems and procedures for selected departments,

(B) Prepare list of key employees and review personnel files, and

(C) Review material contracts and leases.

(7) Review hospital vendor list:

(A) Determine its accuracy and completeness, and

(B) Note suspicious vendors for additional investigation.

(8) Inspection of general ledger:

(A) Note large or unusual transactions, and

(B) Review significant journal entries.

(9) Review of cash disbursements, invoices, and cancelled checks.

(10) Perform test of charges.

(11) Prepare audit evaluation and planning memoranda.

(e) In-depth auditing phase - perform detailed audit procedures on those areas of the hospital selected for audit.

(f) Review workpapers.

(g) Prepare audit report.

PART III : REIMBURSEMENT AUDIT GUIDES

Section 3.1 - Audit Guide for the Review of Cost Reporting,
Cost Finding, and Reimbursement Rate
Setting

The audit tasks associated with reviewing cost reporting, cost finding, and reimbursement rate setting can begin in the target selection process or in the initial stage of the audit. Although the prime objective is to identify manipulation and misrepresentation of reported costs, the review procedures are designed to disclose pertinent information about the hospital, and pinpoint unreasonable and inconsistent data pertaining to operating revenues and expenses which require additional audit and investigation. The auditor must understand, however, that, in order to review cost finding thoroughly, knowledge of the hospital's operations and the cost finding process must be obtained. This section describes the audit procedures that can be utilized in the investigation of fraud and abuse in the cost reporting and reimbursement process. As such, it is addressed to detecting and documenting deceptive practices affecting Medicare and Medicaid where Medicaid reimbursement is based upon the Medicare cost report.

The concept of reasonable costs for Medicare Part A purposes is uniform throughout the United States. Medicaid varies from state to state, with reimbursement based on reasonable costs as in Medicare, or on some other approved basis but not higher than reasonable costs for Medicare purposes. Blue Cross plans vary from region to region even within states. Blue Cross reimbursement may be based on costs, charges, negotiated rates, diagnostic related groups, or some other basis. It is essential that the auditor become familiar with the different methodologies used by the various third-party payors in the investigative unit's region. Medicare forms and regulations, particularly HIM-15, must be reviewed and understood. The state agency administering Medicaid will have the regulations, administrative rulings, forms, and other information concerning cost reporting and reimbursement. Blue Cross manuals and regulations should be obtained and studied.

Section 3.1.1 - Maximizing Reimbursement

The reimbursement environment has encouraged hospitals to establish priorities based on what is or will be reimbursed. Within the regulations it is possible to maximize reimbursement by taking certain specific actions. Some of these are:

(a) By providing only reimbursable services, a hospital avoids any uncovered expenses. Such a hospital might not provide private duty nursing service, or not engage in research, for example.

(b) Costs can be directly reclassified rather than allocated through the cost finding process. E.g., if in a hospital which has low Medicare utilization in the radiology department and high inpatient Medicare utilization, employees who transport patients from their rooms to the radiology department may be specifically identified and their salaries reclassified from radiology directly to the inpatient area served.

(c) The cost allocation statistics used could be those providing the maximum reimbursement. E.g., a hospital can choose to allocate housekeeping based on "square feet serviced" or "actual time spent." The hospital can thus use the statistic which shifts housekeeping costs in the manner which maximizes reimbursement.

(d) If a hospital has an affiliation agreement with another institution (most teaching hospitals have such an arrangement), costs (e.g., physicians' salaries, equipment purchases) can be shifted between the institutions, thus benefiting either one or both of them.

Section 3.2 - Examples of Fraudulent Practices

(a) The following are examples of the types of practices that may be encountered in reviewing the provider's cost reports. Some of these practices may not have an impact on reimbursement because of variations in reimbursement methodology.

(1) Understating patient days or visits. In computing Medicare percentage of utilization, the omission of days from total days would increase the ratio of Medicare to total days and thereby increase reimbursable costs.

(2) Overstating admissions and discharges. This practice would reduce or eliminate a length of stay penalty since this is computed by total patient days divided by discharges.

(3) Billing Medicare on the wrong line for ancillary charges. This would allow a provider to increase the Medicare utilization percentage for the department affected. E.g., if a laboratory had a higher than average aggregate cost, another ancillary, such as physical therapy, might be charged as laboratory on the Medicare bill. At year end, the ratio of Medicare charges to total charges

in laboratory would be inflated resulting in over-reimbursement.

(4) Shifting costs to avoid penalties or ceiling disallowances. Since various types of services are subject to reimbursement limitations, ceilings or penalties, providers may shift costs from one area to another to avoid them. This can be done by journal entry, reclassification of costs, alteration of the statistical bases of allocation, selectively combining general ledger accounts to the cost report, or reclassification on the cost report itself. E.g., a hospital may shift ancillary costs to routine care centers, or outpatient to inpatient, or emergency room to clinic.

(5) Altering statistics. Statistics used for cost allocations could be manipulated to place costs in centers which receive greater reimbursement. E.g., by eliminating the square footage statistic for a non-reimbursable cost center, the provider could shift maintenance, depreciation and related costs to reimbursable cost centers.

(6) Failing to offset the retained portion of physicians' fees against appropriate expense. Some hospitals bill on behalf of physicians and retain a

portion of the fees, but frequently fail to offset and reduce appropriate expenses by the amount of fees retained.

(7) Increasing equity of proprietary providers by failure to write off bad debts, by overstating assets, by understating liabilities, by unnecessary borrowing from owner, by investments in assets not related to patient care, and other practices. (Note: proprietary providers are allowed a percentage return on equity capital as an element of reasonable cost of services to patients. HIM-15, Chapter 12.)

(8) Misrecording income to avoid detection and offset against costs. Revenue, such as a rebate from a vendor, should be reported as unrestricted income and disclosed properly so that the intermediary or fiscal agent can determine if recovery against expense is appropriate.

(9) Failure to offset (reduce) interest expense by unrestricted investment income. HIM-15, Part 1 § 202.2 provides that when invested funds from gifts or grants which are unrestricted are commingled with other funds, the income from the investments must be used to reduce allowable interest expense.

(10) Inclusion of inappropriate rentals as capital cost to avoid routine or operating cost ceilings. Examples of this are payments for copying machines, autos, and other items that are not capital leases.

(11) Inclusion of costs not directly related to patient care in reimbursable cost centers. E.g., costs associated with doctors' private offices, research, unapproved education.

(12) Abandoned construction costs are a non-allowable investment loss but are frequently written off to operating expense.

(13) Capitalizing routine maintenance to avoid ceilings; routine maintenance should be expensed in the period in which it is incurred.

(14) Claiming an area as an intensive care unit when it is not. This is significant when the hospital has a high proportion of Medicare patient days in the unit claimed to be an intensive care unit.

(15) Inclusion of costs for services not used by Medicare patients in those departments which usually are heavily utilized by Medicare in order to maximize Medicare reimbursement.

(16) Pricing-up charges for procedures frequently used by Medicare patients. As a result, charges as related to costs are not reasonable and the RCCAC settlement (ratio of charges to charges to costs) is distorted.

(17) Charging higher prices to Medicare patients distorts the RCCAC settlement.

(18) Understating direct expense in low-or non-reimbursable areas has the effect of under allocating overhead (administrative and general) to these areas in the cost finding process. (E.g., fund raising, private practice, research, coffee shop are non-reimbursable; home health care, outpatient, emergency room are low-reimbursed areas.)

(19) Basing rate appeals on misleading data.

(20) Taking recoveries against inappropriate cost centers such as those which are non-reimbursable when related costs are actually in reimbursable cost centers. E.g., the sale of used X-ray film may be offset against non-reimbursable research when it should be offset against radiology costs.

Section 3.3 - Procedures for Auditing Cost Reports,
Cost Findings and Reimbursement Rate
Setting

(a) These are the audit procedures for reviewing the following documents which should be obtained in the preliminary stage of the audit:

<u>Document</u>	<u>Description</u>
HCFA-2552 (Formerly SSA -2552) Hospital and Hospital-Skilled Nursing Facility Complex Statement of Reimbursable Cost	Provider's annual cost and information report including cost allocation of general service costs (stepdown) and Medicare rate settlement
Audit Adjustments	Independent CPA, Medicare intermediary
Appeals	Provider's submission, decisions, rate adjustments sheets and supporting documentation

Operating Certificate	Bed complement authorized by the state health department
Policy and Procedures Manual	Operating and administrative plan required by Joint Commission on Accreditation of Hospitals (JCAH)
Crosswalk or Combination Schedule	Tie-in of provider's general ledger to specific lines in the cost report

(b) The auditor should perform a coordinated review of the above documents. Special attention should be given to year-to-year comparisons of costs and statistics for shifts or changes which do not result from changes in the operation but merely maximize reimbursement. The auditor should look for inconsistencies between periods and between documents, illogical relationships, and unreasonable amounts.

(c) HCFA-2552 (Hospital and Hospital-Skilled Nursing Facility Complex Statement of Reimbursable Cost):

(1) The auditor should become familiar with the data contained in this report for background purposes and for subsequent checking to other documents.

(2) Note data which is incomplete or omitted, and investigate.

(3) Statistical data (where comparable with other documents) should be reconciled to HCFA-2552 and discrepancies investigated. (E.g., the bed complement or patient days may have been changed to maximize reimbursement.)

(4) Various data, such as patient services, construction projects, contractual agreements, educational programs, satellite programs, properties, and property rentals, should be compared to and adequately reflected in HCFA-2552 and supporting financial statements.

(5) Changes in bed complement may affect occupancy calculations and, if substantial, should be checked against rate calculations.

(6) Gross charges, patient days, and ambulatory visits for Medicare patients should be reviewed for reasonableness in relation to the Medicare rate computations. Medicare ICU days should agree with the rate computation.

(7) Review the rate computation settlements:

(A) Determine the effect of penalties and consider the possibility a shift of costs may have been made to avoid such penalties (e.g., occupancy, length of stay, routine ceilings, ancillary ceilings, utilization).

(B) Determine (i) ratios of routine and ancillary costs to charges and ratios of Medicare charges to total charges, and (ii) the possibility a shift of costs or Medicare charges may have occurred to increase reimbursement (this would be accomplished either by shifting costs to a high Medicare utilization department (e.g., cardiology) from a low Medicare utilization department (e.g., occupational therapy), or by billing for ancillaries on the wrong line on the billing form, or by discrimination in the charge structure).

(C) Compare provider's ancillary statistics (if available) for Medicare and non-Medicare patients to the ratio of charges to charges on the Medicare settlement and investigate discrepancies (e.g., one hospital reported a 50/50 distribution of statistics for laboratory, but the percentage of Medicare charges to total charges was 90%).

(D) If the departmental method is being used for routine cost determination, compare per diem charges for Medicare patients to per diem charges for all patients; investigate the possibility that the charge structure is not uniform where differences occur.

(E) Review all rate computations for errors.

(8) Review available operating statistics (not statistical basis for cost allocation) for general background information: patient days by service (e.g., medical-surgical, pediatrics, maternity), bed complement, ancillary services (e.g., treatments, procedures, examinations), visits (e.g., clinic, emergency room, referred ambulatory).

(9) Compare available operating statistics to cost allocating statistics. Note and investigate discrepancies or inconsistencies. E.g., where salaries are a basis for cost allocations, the departmental salary expenses should agree with the salary statistics in these departments; e.g., ambulatory procedures are listed in the tabulation for procedures, but no charges for ambulatory patients may be noted in the revenue sections.

(10) Review the independent auditors' opinion and the notes to the financial statements included in the hospital's audited financial statement. Significant information not contained on HCFA-2552 is often formed here.

(11) Examine the balance sheet and statement of changes in fund balances for all funds (statement of capital and retained earnings in case of a profit making entity):

(A) Tie in beginning and ending balances.

(B) For not-for-profit providers, tie in the statement of patient service revenues and statement of expenses to the statement of changes in fund balance for the operating fund.

(C) Determine the general nature of all hospital funds (e.g., restricted, board designated, endowment, building, funded depreciation).

(D) Determine the propriety of inter-fund transfers; investigate items not included in operating fund income for possible recoveries (e.g., investment income, unrestricted endowment fund income, special fund income, contributions, rebates).

(E) Evaluate the reasonableness of the respective fund earnings. Be wary of substantial "Special Funds" in a situation where the unrestricted fund has to borrow to cover deficits. Large dissipations of funds should also be noted for investigation.

(F) Determine if depreciation is funded.

(G) Determine the overall financial condition of the hospital in terms of income and cash flow and ascertain need for loans, need to maximize reimbursement, need to cut services, and reasons for strong or weak financial position.

(H) Review receivables in all funds for possible cost recoveries which may also have been omitted from the operating fund in order to make detection less likely (e.g., "Accounts Receivable-Physicians" in a "Special Fund" may represent private office charges by the hospital).

(I) Determine whether equity for proprietary hospitals is inflated by including things such as overstated receivables, loans payable erroneously buried in equity, investments, fictitious assets, fully depreciated assets maintained on the books at appraised values, and surplus working capital. Some of these situations will be detected only by extended auditing, while others may be uncovered during a basic review of the HCFA-2552, independent auditors' and Blue Cross workpapers.

(12) Examine patient service charges on Departmental Cost Distribution Schedule to HCFA-2552:

(A) Analyze relative importance of various outpatient and ancillary departments and compare net receipts to costs to determine services operating at a deficit. Investigate the cause of this.

(B) Determine the proportion of charges represented by clinic, emergency room and ancillary services, and compare to operating statistics for each revenue department in order to detect shifting of costs to areas of greater reimbursement (usually to inpatient) when statistics are used for cost allocation.

(13) Examine the Reclassification and Adjustment of Trial Balance of Expenses Schedule to HCFA-2552:

(A) Determine whether other operating revenues have been taken as recoveries as appropriate for Medicare.

(B) Determine whether non-operating revenues have been taken as recoveries as appropriate for Medicare.

(C) Note significance of Medicare bad debt allowances for possible review.

(D) Review magnitude of expenses in various departments for overall reasonableness.

(E) Divide departmental salaries by the number of full-time equivalent employees (if available) in order to detect shifting of costs or statistics. E.g., for a given department the average wage is calculated to be \$2,000; this is highly unlikely and could mean that salary expense has been shifted to other centers at some stage in the cost reporting.

(F) Tie in expenses reported to beginning stepdown costs.

(G) Review independent auditors' workpapers for tie-in to general ledger and note the propriety of classifications of general ledger accounts.

(14) Scan general ledger for unusual journal entries and investigate to detect inflated or misclassified expenses. Note particularly material year-end adjusting journal entries or reclass entries.

(15) Review Reclassification of Expenses Schedule to HCFA-2552:

(A) Determine reimbursement effect and evaluate reasonableness.

(B) Review consistency and magnitude in relation to prior periods.

(C) Ascertain that related statistics have been changed along with reclass entries. For example, if certain salary costs were reclassified from one department to another, likewise the related salary statistics should also be changed.

(16) Review Recoveries of Expenses Schedule to HCFA-2552 for reasonableness:

(A) Compare to other operating and non-operating revenue and investigate income not taken as a recovery.

(B) If cost has been used as the basis for recovery, compare the cost to the related income to detect any possible understatement.

(C) Determine whether any recoveries should be post-stepdown recoveries. By posting recoveries to certain cost centers prior to the stepdown, the hospital could avoid a fair allocation of indirect costs, such as administrative and general. When recoveries are made against non-reimbursable cost centers, the routine and ancillary centers would absorb more than a fair share of overhead.

(D) Determine whether recoveries are taken against the proper cost center (e.g., offsetting X-ray scrap income against administrative costs would be improper.)

(E) Investigate potential recoveries greater than costs (e.g., where the income exceeds purported cost).

(F) Investigate negative recoveries which increase operating cost.

(17) Review Cost Allocation - Statistical Basis and Cost Allocation - General Service Cost Schedules to HCFA-2552:

(A) Review statistics for reasonableness and investigate those which differ from the recommended basis for allocation.

(B) Investigate significant changes from prior periods in the proportion of costs allocated to various cost centers, especially shifts from outpatient to inpatient, routine to ancillary, non-reimbursable to reimbursable cost centers.

(C) Investigate reasons for a change in the statistics from a prior period.

(D) If the same type of statistic (e.g., square footage) is used for more than one cost allocation, determine that the same statistic is actually assigned to each function consistently.

(E) If salaries are used as the basis for cost allocations, compare the statistical basis to the statement of expenses

(departmental salaries). Investigate any significant differences. (Note: statistics should reflect changes based on reclassifications of expense.)

(18) Review any changes in certified bed capacity in conjunction with HCFA-2552 data for possible reimbursement effects (e.g., penalties, cost allocations).

(19) Review income from unrestricted and restricted funds, gifts and grants, and determine whether recoveries were properly taken according to the regulations. HIM-15, Sections 202.2 and 600.

(20) Determine whether depreciation methods and lives are consistent. Also, review reasonableness of net depreciation adjustments.

(d) The auditor should review Cost Allocation-General Service Costs Schedule to HCFA-2552:

(1) Review audited stepdowns.

(2) Review the intermediary's computer printout of the comparative analysis of costs and statistics for the current and prior periods

(whenever available) for significant changes. Determine reasons for significant shifts in costs (e.g., from outpatient to inpatient, non-reimbursable to reimbursable cost centers, routine to ancillary cost centers). Determine reimbursement implications.

(3) Develop cost and related income analyses and review for reasonableness, and determine profitable and unprofitable services for clues as to where costs or income may have been shifted to maximize reimbursement. Examples of such analyses are:

(A) Patient Service - Excess of Revenue over Expense. Gross revenue per the cost report is reduced by third party allowances and then by the stepdown cost to arrive at the excess of revenue over expense for each patient service (e.g., inpatient general, pediatrics, maternity, ambulatory service). If the auditor notes that private ambulatory services produce a profit, but all other types show a loss, this area should be pinpointed for further investigation since costs may have been shifted to reimbursable cost centers.

(B) Excess of Revenue over Expense by Routine and Ancillary Cost Centers. Gross revenue per the cost report for significant revenue centers should be compared to the stepdown cost for such centers and the excess of revenue over expense calculated. This analysis may indicate a pattern, such as disproportionate losses in cost centers heavily utilized by Medicare patients, or of declining losses in outpatient areas, all resulting from shifts of income or costs.

(C) Revenue and Cost per Test or Procedure. Gross charges per the cost report are divided by the number of tests or procedures for departments such as laboratory and radiology. Stepdown costs are then divided by the number of tests or procedures, and the results are compared. Divergent trends such as declining income and increasing costs in the same department should be noted for further investigation.

(D) Outpatient Costs. Compute outpatient costs per visit from the stepdown costs by dividing total cost for general service and ancillary components by the number of visits. Divergent trends, such as a rising general service component along with a declining ancillary costs component, should be noted for further investigation.

(e) The independent auditors' and the fiscal intermediary's audit workpapers should be reviewed:

(1) Determine the relative intensity of review by others in all areas in order to avoid unnecessary duplication of effort, and determine those areas where potential fraud and abuse are most likely to have been overlooked.

(2) Note weaknesses in internal control which present opportunities for wrongdoing.

(3) Review audit adjustments for reasonableness and consistency with prior periods. Examine passed adjustments (i.e., proposed but never made) for propriety.

(4) Review classifications of general ledger accounts for reasonableness and consistency between periods.

(5) Determine reasons for incomplete audit procedures.

(6) Evaluate comments and explanations for clues to areas that require investigation.

(7) Adjusting journal entries especially those involving interfund transactions, equity, and accruals of expense should be carefully reviewed for reasonableness.

(8) Review all schedules, analyses, computations, correspondence, management letters, and other pertinent documentation for possible reimbursement implications.

(9) Note all transactions with related persons or organizations for further investigation.

(10) If available, compare information tax returns (e.g., Internal Revenue Service Form 990) to hospital financial statements, for items such as officers' salaries, fund raising expenses, and compare to Medicare Cost Report.

(f) The auditor should review all provider appeals:

(1) Evaluate appeals for reasonableness and determine possible illogical, inconsistent, or fallacious bases.

(2) Determine whether completed or pending appeals have been audited. If not, consider doing this.

(3) Determine whether appeals based on new services reflect changes (e.g., discontinued clinic) in other services.

3.4 - The New York Experience

(a) In New York State, hospitals file annually a Uniform Financial Report (UFR), a Uniform Statistical Report (USR), and related supplements for Medicare, Medicaid, and Blue Cross. These reports are in lieu of HCFA-2552. The stepdowns and rate calculations are based on these reports. Medicaid rates are calculated by the State Department of Health based on adjusted stepdowns reflecting Medicaid principles of reimbursement. Medicaid reimbursement in New York is prospective, that is, the rate is determined before a fiscal period has begun. There has been a two-year lag between report filing and rate setting; adjustments are made for inflation between filing and effective date.

The State of New York through the Department of Health has from time to time promulgated regulations providing for certain limitations (ceilings) and penalties in an effort to control hospital costs. These apply both to the Medicaid rate and to the Blue Cross rate and can be described generally as follows:

- (1) Prospective rates based on actual costs experienced in a base year (two years before) and adjusted for inflation. This base is not adjusted to reflect actual costs at a later date.

(2) Ceilings on per diem costs for routine and ancillary services are based on the computation of peer group averages.

(3) Routine medical and surgical inpatient costs are reduced in rate setting by a penalty if a facility's length of stay (patient days divided by discharges) exceeds the average for the group plus one-half day.

(4) Patient days will be imputed if occupancy falls below a stipulated level. This results in a lower per diem reimbursable cost.

(5) Maximum capitation reimbursement for emergency room and outpatient clinic visits is set by the state Department of Health for Medicaid.

(6) Medicaid cost reimbursement in New York State follows generally the Medicare principles of reimbursable costs as described in Provider Reimbursement Manual, HIM-15.

(b) The reimbursement mechanisms described above necessitated the development of specialized audit techniques in addition to those listed for Medicare reimbursement.

(1) The Uniform Statistical Report provides a detailed breakdown of revenue and patient days by financial class. The general patient mix by third-party payor is reviewed to determine the relative importance of each. The importance of each respective third-party payor to the hospital's revenue indicates to the auditor the areas having the most vulnerability to fraud and abuse, and consequently where to concentrate the examination of the cost finding and reimbursement process.

(2) The cost finding process for Medicaid and Blue Cross includes additional cost allocations not found in Medicare cost finding. Ancillary service cost centers are allocated to routine patient services, ambulatory services, and non-reimbursable cost centers. The cost allocation bases are either statistics or gross charges. The final allocated costs are used to determine per diem or per visit reimbursement rates. A comparison of gross charges to statistics is prepared in order to detect discrepancies. (E.g., in the electrocardiograph ("EKG") area, ambulatory revenue constituted 20% of total EKG revenue for one hospital. On the UFR, the statistical basis indicated that only 15% of the EKG activity was directed to ambulatory care. This

could indicate a deliberate attempt to shift EKG costs to inpatients, since the 15% would be used to allocate costs, thus decreasing the costs allocated to the ambulatory area which generally results in greater reimbursement to the hospital.)

(3) The Medicare fiscal intermediary prepares four stepdowns or cost allocation schedules. One each is prepared for Medicare (as found on HCFA-2552), Blue Cross, and Medicaid; a fourth stepdown, referred to as the American Hospital Association ("AHA") stepdown is also prepared. Each stepdown is compared to the AHA stepdown in order to detect cost shifts which are investigated.

PART IV : EXPENDITURE CYCLE AUDIT GUIDES

Section 4 - Audit Guides for the Expenditure Cycle

Section 4.1 - Purchasing

The expenditure cycle encompasses the acquisition of goods and services for all departments of the hospital and the payment for these goods and services.

The functions within the cycle are:

- (a) Requisition by operating department,
- (b) Purchasing,
- (c) Receiving,
- (d) Accounts payable, and
- (e) Cash disbursements.

Section 4.1.1 - Description of Purchasing Functions

Purchasing is usually handled by a purchasing department made up of a purchasing agent and a group of buyers. Specialty departments (e.g., dietary, pharmacy, laboratory) may purchase for their own needs. Whether or not specialty purchasing is utilized, purchasing agents are generally alerted to the needs of user departments by requisition from the departments, or from information on perpetual inventory records maintained in central supply.

Purchasing agents should maintain files of vendors used by the hospital. Hospital policy will specify the necessary authorization at various levels of purchasing.

Once a vendor has been selected, a purchase order is generated to initiate or confirm the purchase with the vendor. Copies of these purchase orders should be maintained by the purchasing agent, central receiving, the user department, accounting, and the vendor.

When goods are delivered or services rendered, the purchasing department should be notified, and all copies of the purchase order appropriately updated. The purchasing department's function with respect to the transaction is then essentially complete.

A centralized receiving department will generally log in merchandise received. The logging procedure should involve checking the invoice to a purchase order, preparing a receiving report, informing the departments holding a copy of the purchase order of receipt of the goods, and forwarding the merchandise either to the user department or to central supply.

Accounts payable should match the purchase order, receiving report, invoice and other documentation when all are received. At this point, the liability (account payable) and account charge (expense) are recorded. The controller's department is responsible for the payment of all liabilities and obligations of the hospital.

Section 4.1.2 - Audit Objectives (Purchasing)

Purchasing is a critical area in that it represents approximately 20 - 30 percent of total hospital operating expenditures and directly affects the reimbursement rate of the hospital. The audit objective is to uncover incidences of one or more of the following improper practices:

- (a) Kickbacks to hospital employees,
- (b) Receipts of rebates, discounts, or allowances that are not properly recorded as offsets to expenses,
- (c) Incurring of expenses not related to patient care, and including those expenses with reimburseable costs,
- (d) Undisclosed relationships between vendors and hospital personnel, or
- (e) Embezzlements by employees.

Section 4.1.3 - Vendor Kickbacks

One of the most common illegal practices in the purchasing area is the vendor kickback to a hospital employee. The auditor should be aware that the possibility exists, and that there may be an arrangement, whereby a supplier would be willing to give a hospital employee cash and other consideration in order to secure hospital business. In order to cover up the kickback and to recoup its cost, the vendor may engage in one or more of the following practices in dealing with the hospital as a customer:

- (a) Inflate prices for merchandise,
- (b) Inflate quantity of merchandise shipped,
- (c) Substitute inferior merchandise,
- (d) Not deliver invoiced merchandise,
- (e) Submit duplicate invoices for merchandise delivered,
- (f) Receive duplicate payment for the same invoice,
or
- (g) Submit invoices for fictitious transactions.

Kickbacks may be made in cash, by check, or by giving other valuable consideration such as automobiles, free goods, vacations, or the use of charge or credit cards. The recipient of a kickback may designate some person to be the beneficiary of the consideration either directly, or indirectly by having the vendor put someone (e.g., a family member) on the vendor's payroll as an employee.

Section 4.1.4 - Rebates, Discounts, and Allowances

Vendors often give purchase discounts or rebates as a normal business practice. The reimbursement regulations require that discounts and rebates be offset against the related purchase. Therefore, the auditor must ascertain whether discounts and rebates have in fact been accounted for as an offset. The same is true of purchase returns and allowances. Payments for cash discounts, rebates, or purchase returns and allowances should be recorded in the cash receipts book; any non-cash transaction should be recorded in the general journal, purchase returns and allowances book, or as a contra item in the purchase journal. Discounts, rebates, purchase returns and allowances may be incorrectly recorded in a fund other than the operating fund, such as a "Physician Continuing Education Fund." In addition, a vendor may make, at the request of the hospital, a contribution to an outside organization, such as the "Women's Auxiliary," which will in turn make a donation equal to the rebate to the hospital.

It should be noted that in many cases the vendor is unaware of how the hospital has accounted for the discount, rebate, or purchase return or allowance. Therefore, the vendor may be willing to disclose its sales to a particular hospital and the credits given to the hospital on those sales.

Section 4.1.5 - Expenses Not Related to Patient Care

During the review of invoices and cash disbursements, the auditor should be aware of the possibility of the existence of expenses not related to patient care and, therefore, not reimbursable. In addition, assets purchased by the facility may not be in any way related to the care of hospital patients.

The auditor should also be aware that hospital employees may be purchasing goods or services for themselves and charging them to the hospital. For example, furniture may be purchased from a vendor and shipped to an employee's home; an employee may charge a vacation to the hospital; a decorator may provide services in an employee's home; or a swimming pool may be constructed at an employee's home by the engineering department staff with materials purchased by the hospital. There are an infinite number of schemes by which an employee can charge personal expenses, that is, expenses not related to patient care at the hospital. Very often the purchases are made in conjunction with other authorized purchases and are drop-shipped at the employee's residence. For example, an employee may order television sets for a hospital and have one shipped to his or her home.

Section 4.1.6 - Undisclosed Non-Arm's Length Relationships

The reimbursement regulations provide for the disallowance of a certain portion of non-arm's length transactions. A hospital director or employee may be found to have an interest in, control of, or relationship with a vendor doing business with a hospital. If the auditor suspects that a relationship between a hospital employee and a vendor exists, a background investigation of the vendor should be made utilizing such sources as Dun and Bradstreet and official state, county, and local records. (See Investigative Manual, Part 3, Sec. B.)

Section 4.1.7 - Employee Embezzlements

The auditor should also be aware that a dishonest employee can embezzle funds from a hospital by submitting invoices from a non-existent company, or by having the hospital make purchases from a vendor in which the employee has an interest or over which the employee has control. In most cases, there will be a short shipment or non-delivery of supplies or non-performance of services.

Section 4.1.8 - Internal Control (Purchasing)

Section 4.1.8.1 - Review of Internal Control and Procedures
Relating to the Purchasing Function

(a) Review the policies and procedures in effect for this function.

(1) Interview the person in charge of purchasing and subordinates, and

(2) Document purchasing department practices in the workpapers.

(b) Because the work of the purchasing department is to procure the right quantity and quality of goods and services at the right time and at the right price, internal control in this area should be documented and evaluated. Consider the following as sound control features:

(1) Use of approved requisitions,

(2) Need for purchase order approvals,

(3) Accountability for purchase orders (numerical control),

(4) Use of approved vendor lists,

(5) Documentation of low bid selection and justification for exceptions,

(6) Prices and terms recorded on purchase order,

(7) Use of approved chart of accounts for account distribution,

(8) Segregation of duties and separation of storekeeping, accounts payable, and receiving from purchasing,

(9) Overall management review,

(10) Established policy regarding conflict of interest.

(c) Based on the review of internal control, the auditor should note any weakness in the system. Examples of weaknesses conducive to fraud include:

(1) Purchasing agents have complete control over ordering procedure,

- (2) Lack of competitive bidding,
- (3) Receiving department is under the control of the purchasing agent,
- (4) Purchasing agent is an owner or relative of the owner, director, or administrator,
- (5) Purchasing agent approves invoices for payment,
- (6) Accounts payable clerk works under the supervision of the purchasing agent,
- (7) Stock room and receiving departments are combined,
- (8) Administrator or owner selects vendor and approves the invoices for payment,
- (9) The exclusive use of a few select vendors.

Section 4.1.8.2 - Review of Internal Control and Procedures
Relating to the Receiving Function

(a) Review the policies and procedures in effect for the function:

- (1) Interview the receiving department head,
- (2) Determine the identity and duties of personnel, and
- (3) Document the procedures in effect.

(b) The auditor should evaluate internal control to assure that goods are received as ordered. Consider the following sound countrol features:

- (1) Preparation and issuance to accounts payable of pre-numbered receiving report forms,
- (2) Segregation of receiving duties from stores and purchasing,
- (3) Matching of goods received to purchase orders,
- (4) Control over shortages, overages, and damaged, returned, and outdated goods, and
- (5) Centralized receiving areas.

(c) The auditor should note weaknesses in this area. Examples of weakness conducive to fraud: see Section 4.1.8.1(c) (3) and (7).

Section 4.1.8.3 - Review of Internal Control and Procedures
Relating to Accounts (Vouchers) Payable

(a) Review the policies and procedures in effect for this function:

(1) Interview the accounts payable supervisor and subordinates,

(2) Determine identity and duties of personnel in the area, and

(3) Document the procedures in effect.

(b) The auditor should evaluate internal control to assure that the liabilities and expenses for authorized goods and services are properly recorded. Consider the following sound internal control features:

(1) Segregation of duties from purchasing, receiving, inventory, cash disbursement, and general ledger,

(2) Forwarding all pertinent documents (e.g., invoices, purchase orders, receiving reports) directly to accounts payable,

(3) Prompt recording of invoices,

(4) Control over continuity of entries,

(5) Use of a current approved chart of accounts for distribution,

(6) Comparison and audit of invoices to purchase orders, receiving reports, or in the case of services other evidence of performance,

(7) Follow-up of unmatched documents,

(8) Periodic reconciliation of vendor statements to open invoices,

(9) Adequate filing and retrieval systems.

(c) The auditor should note weaknesses in this area. Examples of weaknesses conducive to fraud: see Section 4.1.8.1 (c) (5), (6), and (8).

Section 4.1.8.4 - Review of Internal Control and Procedures
Relating to Cash Disbursements

(a) Review the policies and procedures in effect for this function:

- (1) Interview the supervisor of the section,
- (2) Determine the identity and duties of personnel in this area, and
- (3) Document the procedures in effect.

(b) The auditor should evaluate the system of internal control to assure that only approved liabilities are paid. Consider the following sound internal control features:

- (1) Segregation of accounts payable from check signing, check mailing, and cash reconciliation,
- (2) Board authorized check signers,
- (3) Presentation of approved voucher package to check signer,

(4) Review and approval of voucher prior to check signing,

(5) Marking voucher "Paid" or equivalent,

(6) Prompt recording of cash disbursements in a register or journal,

(7) Use of check writers,

(8) Control over facsimile signature plates,

(9) Use of, and accounting for pre-numbered checks,

(10) Safeguarding unused checks,

(11) Mutilating and retaining spoiled or cancelled checks,

(12) Two signatures on large checks,

(13) Control of bank transfers,

(14) Prohibiting checks payable to "Cash",

(15) Delivery of bank statements to persons other than check preparers,

(16) Prompt reconciliation of bank statements,

(17) Supervisory review of bank reconciliations.

(c) The auditor should note weaknesses in this area. Examples of weaknesses conducive to fraud -because of the sensitive nature of cash disbursements the absence of any one or more features described in (b) above would be conducive to fraud unless some compensating controls exist.

Section 4.1.9 - Audit Procedures for Reviewing Transactions
in the Expenditure Cycle

The review procedures for cash disbursements and purchase invoices that follows are not mutually exclusive. The findings in one area should be used to supplement the review of the other area.

The auditor may decide to limit the scope of the initial review of disbursements and purchase invoices as a result of the evaluation of internal controls or the large volume of documents existing in a particular hospital. For reviewing checks paid by the hospital, the initial sample could consist of selected test months or selected payments, or both, obtained from the cash disbursement records. The initial review of purchase invoices could be limited to (a) certain test months based on a review of the purchase journal, (b) certain vendors based on allegations or exceptions noted in the prior reviews, or (c) certain types of expenses based on an analysis of comparative costs or statistics.

Section 4.1.9.1 - Cash Disbursements

(a) Several preliminary steps should be performed before disbursements are to be examined:

(1) Obtain a list of all bank accounts,

(2) Obtain a list of authorized check signatories for all accounts,

(3) Obtain the cancelled checks, check stub books, debit and credit memos, deposit slips, bank statements, reconciliations, and passbooks for all accounts, and

(4) Obtain the cash disbursements journals.

(b) Audit Procedures:

(1) Test to determine that all checks have been made available for review by selecting a test period, counting the number of cancelled checks and debit memos enclosed in the bank statements, and comparing the count to the total debits indicated on the bank statement;

(2) In the review of cancelled checks for a test period, the auditor should determine whether a check exists for each entry in the cash disbursements journal;

(3) The following are exceptions that should be investigated:

(A) Checks with creases or folds are indicative of checks that were hand-delivered as opposed to being mailed. Another indication of hand-delivered checks are those with clearing dates on or relatively close to the date of issuance. Often, when kickbacks are made, the vendor will go to the hospital, deliver a phony invoice to cover the amount of the kickback, and simultaneously receive a check in the amount of that invoice from the hospital and pay the kickback.

(B) It has been found that vendors must generate cash for the purpose of giving a kickback. One way of generating cash is to keep a transaction from being recorded on the vendor's books and records; by cashing a check received from the hospital, the vendor can generate cash and at the same time avoid

recognizing the income. Other means of diverting funds received by a vendor include double endorsing checks to other parties, and endorsing checks with a name different than the payee's name (e.g., a check payable to the "XYZ Corp" may be endorsed "XYZ Co."). Such minor deviations are not generally picked up during the vouching of checks performed by the independent accountant. Banks are usually very reluctant to cash checks made out to businesses, especially to corporations, but by opening an account for an entity which is purportedly a sole proprietorship (e.g., "XYZ Co."), the vendor may succeed in getting the bank to cash a check made out to or endorsed by that entity ("XYZ Co."). In other words, the bank would cash a check payable to or endorsed to "XYZ Co." more readily than a check payable to "XYZ Corp."

(C) Checks that are deposited in a bank in the proximity of the hospital and not where the vendor/payee is located, or checks in an account or in a bank other than that normally used by the vendor for the deposit of receipts may be indicative of receipts not being recorded by the vendor.

(D) Checks issued out of numerical or chronological sequence may be indicative of a questionable payment to a vendor.

(E) Vendors paid before the general population should be investigated as to the reason for preferential treatment. Hospitals generally have cash flow problems and may take anywhere up to 180 or more days to pay vendors.

(F) Checks payable to employees for other than payroll may be a way of compensating them for services either not performed, or not related to patient care.

(G) Memo entries on cancelled checks or in the check stub book may be evidence of fraudulent intent.

(H) Checks endorsed by hand as opposed to a rubber stamp endorsement may indicate that the payee's (vendor's) operation is a sham. Such entities often are no more than brokers or drop-shippers buying from legitimate wholesalers, increasing the price to the hospital, and splitting the increase with

someone at the hospital. Entities of this nature will sometimes make deliveries in order to appear legitimate, but often they will have their legitimate supplier deliver the merchandise in their name and bill the broker. The broker then bills the hospital for the shipment at an inflated amount.

(4) After reviewing cancelled checks, questionable disbursements should be traced to the cash disbursements journal to note accounting treatment.

(5) A general review of the cash disbursements journal should be made by the same auditor who has reviewed the cancelled checks. The review of each month's entries in the cash disbursements journal should be done in conjunction with the review of that month's cancelled checks. Some of the items to look for during the review of the cash disbursements journals are:

(A) Missing pages - all pages should be provided to the auditor.

(B) Entries to the general column may indicate unusual purchases, or unusual dispositions of cash.

(C) Erasure, crossing-out, white-out, and other void on any part of an entry may be an attempt to cover up the true nature of a transaction. A voided entry in the cash disbursements journal should be followed up to determine the reasons for the void. E.g., where a disbursement entry is meant to be paid to a fictitious vendor who is in fact a hospital employee, the name of the employee may accidentally be written in and subsequently voided out, or covered up in some way. All discrepancies between checks and cash disbursement entries should be investigated.

(D) Direct expenses paid through the cash disbursements journal and which bypass the accounts payable system should be investigated.

(E) Test footings should be done for selected months to ensure all postings are properly included.

(F) Test tracings of postings to the general ledger should be made.

(G) An unusual or offsetting entry (e.g., debit in the cash column or accounts payable column and a credit to an expense account) is one way that the cash disbursements journal can be utilized to record a rebate. Such an item should be investigated to determine the nature of the transaction and, if a rebate, whether it was properly recorded.

(6) Based on the foregoing, a schedule listing exceptional or suspicious items should be made including:

- (A) Date,
- (B) Check number,
- (C) Payee,
- (D) Account charged,
- (E) Amount,
- (F) Endorsement,
- (G) Disposition - cashed or deposited date and the name and location of the bank,
- (H) Reason for the exception.

Copies of suspect documents should be obtained wherever possible.

Section 4.1.9.2 - Purchase Invoices

(a) The review of vendor invoices is done to identify those expenses not related to patient care, including personal expenses, and to develop investigative leads in the area of questionable vendor practices. In the area of personal expenses, the more obvious of these types of expenses may have been noted either by the hospital's independent accountant or the fiscal intermediary. During their audits, they should have examined such accounts as travel and entertainment, public relations, trips, and conventions, where most of the personal type items would have been recorded. Also, they should have analyzed fixed assets, and repairs and maintenance, where the purchase of furniture and building materials which may have been made for the use of an employee would normally have been recorded. It must be remembered that, although the hospital's independent accountant and the fiscal intermediary may have done some vouching, their objective was to determine if there is an invoice for each purchase, and to verify that all amounts and quantities on the invoices agree with the supporting documentation. The investigative auditor's objective is to look beyond the invoice and obtain answers to such questions as: Does the vendor actually exist? Were the quantities and types of goods shown actually shipped? Is the invoice fictitious?

By performing a 100 percent analysis of an expense account, all that is being done is determining that there is an invoice for each purchase. By doing that, the auditor is merely repeating work that may have been done already. The review must not be mechanical in nature. Each invoice selected must be looked at carefully for the following indicators which could point the auditor to a fraudulent scheme:

- (1) Shipping destinations other than the hospital.
- (2) Unreasonable prices.
- (3) Unreasonably large quantities.
- (4) Weekend or holiday delivery or invoice dates.
- (5) Delivery date does not conform to the vendor's usual pattern of delivery; this could indicate a phony invoice.
- (6) The same person signed the purchase order and the receiving report.
- (7) Proper supporting documents are not attached to all invoices; this could indicate a phony invoice or delivery to a destination other than the hospital.

(8) The goods were delivered by a vendor other than the one from whom the merchandise was ordered; if so, the hospital could have ordered the merchandise directly from the company which delivered it, and this could indicate that the hospital's vendor is a dummy company set up to siphon money from the hospital.

(9) The vendor's invoices to a particular hospital are in perfect sequential order (e.g., 500, 501, 502); this could indicate a dummy or undisclosed related company.

(10) The vendor is paid on a preferential basis; in most kickback situations, the vendor does not kickback until after payment has been made by the purchaser.

(11) The invoices are not properly cancelled to prevent duplicate payments.

(12) There are unusual markings on the invoice.

(13) The sales tax rate charged on the invoices is not the same as the rate in the county in which the facility is located; this may indicate that the goods were shipped elsewhere. (Note: not-for-profit entities are usually exempt from sales tax.)

(14) The invoice is a photostat copy and not an original.

(15) The invoice is handwritten.

(16) The invoice lacks a proper letterhead.

(17) The invoice total is a round dollar amount (e.g., \$100, \$200).

(18) There is an inconsistency in a particular vendor's invoices (e.g., some may be typed and others handwritten).

(b) Based on the foregoing review, a schedule listing exceptional or suspicious items should be prepared to include:

(1) Date of invoice, date entered,

(2) Invoice and number,

(3) Vendor (payee) name and address,

(4) Account charged, description of purchase,

(5) Amount,

(6) Check number and date paid and
endorsement,

(7) Reason for the exception,

(8) Disposition of exception (comments).

Copies of suspect documents should be obtained, if possible.

(c) If, based on invoice review, a vendor requires follow-up, a vendor questionnaire should be prepared by the auditor. A sample of such a questionnaire is contained in the Appendix. The questionnaire should be used as an aid in investigating the vendor. If additional investigation is necessary, a determination should be made as to what course of action should be followed. Based on the auditor's work and on the investigator's findings, certain vendors may be selected for audit.

Section 4.1.9.3 - Preparation of a Major Vendor List

(a) The purpose of a major vendor list is to provide investigative leads through the review of properly categorized vendors. A major vendor list should be prepared using the accounts payable subsidiary ledger showing the vendor name, address and dollar volume of business done with the hospital. The list should be categorized by types of goods or services provided and on a comparative basis for all years under audit. By reviewing the purchases from all vendors who supply a particular type of goods or service, the following questions can be answered:

(1) Why has the volume of purchases changed for a particular vendor?

(2) Why has the hospital suddenly stopped making purchases from one vendor and started with another?

(3) Are all the purchases for a particular area made from one vendor?

(4) Why has the volume of business for a particular category changed significantly between years under audit?

(5) Does a vendor's product line seem unusual or inconsistent? (E.g., a vendor sells both surgical supplies and paper goods.)

(6) If a new purchasing agent was hired, was there a major shift in the vendors used by the hospital?

(7) Are some of the vendors listed used only at this hospital and no other?

(8) Is there more than one vendor at the same address?

(9) Are there unusual swings in volume or changes in vendors in a particular category?

(10) Is there more than one vendor for the same product at the same time.

While any of these factors could be due to normal business practices, the auditor should keep in mind the fact that the existence of one or more is sometimes an indication of a fraudulent practice. Accordingly, the auditor should consider each of these factors items to be examined in detail.

(b) Copies of the major vendor list should be sent to the other members of the investigative unit. The list should be reviewed for the purpose of selecting vendors for further investigation and audit.

Section 4.1.10 - Tracing Findings to the Cost Report

(a) If there is an occurrence of inflated costs, it is necessary to verify that such costs found their way onto the provider's cost report. For example, if the finding is a vendor kickback in the dietary area and the account analysis approach is used, it would be necessary to analyze completely all entries to a food account when the entries from one particular vendor are the only ones of concern. By using the vendor analysis approach, the same objective can be reached in less time. The account analysis approach should be used if there are questions concerning a large portion of the charges to a particular account, as for example, kickbacks or rebates from a number of vendors whose purchases are charged to the same account.

(b) The following is the technique for tying-in an audit finding to the cost report using the vendor analysis approach where a standard accounts payable purchase system is used:

(1) Obtain a thorough understanding of the accounting system in use.

(2) For the vendor under analysis, obtain copies of applicable accounts payable cards.

(3) Trace the questionable invoices to the entries shown on the accounts payable card. If each invoice is not shown individually, perform the necessary audit steps to ensure that the invoice under question is included in the entry shown.

(4) Trace postings on the accounts payable cards to the purchase journal. In a small hospital it may be possible to trace the invoice directly to the purchase journal.

(5) Foot the purchase journal columns in which the vendor entries are shown.

(6) Trace the applicable purchase journal column total to the general ledger.

(7) Review the purchase journal for any possible offsetting credits.

(8) Foot the general ledger account to which the postings from (6) were traced.

(9) Review all adjusting journal entries to the applicable general ledger account to ensure that the amount under review had not been removed.

(10) Trace the general ledger account balance to year-end trial balance.

(11) Review the independent accountant's year-end adjusting journal entries to ensure the item under review has not been removed.

(12) Trace adjusted trial balance to the applicable cost report.

If a proprietary facility is involved, the owners' or partners' drawing accounts should always be analysed in detail to ascertain whether any of the questionable items were charged, either directly or by reclassification, to any of these accounts.

Once it has been determined that the questionable item under review has found its way onto the cost report, it will be necessary to obtain assistance from the various third-party payors to determine whether the item has been reimbursed. Cost ceilings imposed in the rate setting process are extremely important. As noted above (see Sec. 2.2.1), a thorough review of ceiling disallowances should already have been made to ensure that the fraudulent item did have an impact on reimbursement. A particular item may also have been disallowed during an audit or desk review of the cost report, and never reimbursed.

Section 4.2 - Vendor Audits

(a) The procedures detailed in this section should be carried out concurrently with the procedures in Sec. 4.1.

In order to determine if a kickback arrangement exists, the books and records of the vendor should be examined. These records can be obtained either with the consent of the vendor, or by subpoena (if the subpoena power is available).

There are endless ways for a vendor to withdraw funds from the business in order to make a kickback. If the vendor's business does not generate cash and the vendor tries to expense the kickback, it can be hidden in any account. If cash is normally generated in the business, or if the vendor is willing to make a kickback from personal funds, it will be difficult if not impossible to identify it through the company records or the personal bank records of the vendor.

If there is a kickback arrangement, usually at the time of the receipt of a check from the hospital the vendor will draw a check payable to cash, an officer, a hospital employee, or a salesperson and charge it to expense.

This check or the cash received from this check may be given, in whole or in part, to the hospital employee.

Particular attention should be given to accounts such as loans and exchanges, sales returns and allowances, commission expense, and contributions. Accounts of this nature are often used to funnel money out of a vendor to a kickback recipient.

The records needed for a vendor audit include:

- (1) Bank statements, cancelled checks, and deposit tickets,
- (2) Check stub books,
- (3) Cash disbursement books,
- (4) Purchase books and purchase invoices,
- (5) Petty cash books and vouchers,
- (6) Payroll books and employee earning cards,
- (7) Sales invoices, credits, and sales journals including shipping documents, and evidence of delivery,
- (8) Hospital purchase orders,
- (9) Accounts receivable ledger cards,
- (10) Cash receipt books,
- (11) General ledger and general journal,
- (12) Income tax returns,
- (13) Correspondence files, and
- (14) Vendor's financial statements.

(b) To make a thorough comparison between the hospital's transactions and the vendor's, it is necessary to obtain the following records from the hospital:

- (1) Purchase orders,
- (2) Purchase invoices,
- (3) Receiving reports,
- (4) Checks issued to vendor, and
- (5) Accounts payable ledger card.

Section 4.2.1 - Examples of Fraudulent Practices (Vendors)

The following are some typical examples of fraudulent practices disclosed by vendor examinations:

(a) The vendor agreed to pay the purchasing agent, administrator, and department head a percentage of monthly purchases. A dummy invoice was submitted each month to cover the kickback. The auditors noted in one such case that the invoice was always issued in the fourth week and always approximately 5 percent of purchases. Another vendor had the practice of noting the computation on his billing copy with the initials of the recipient next to it.

(b) A cleaning supplies vendor issued fictitious invoices for merchandise which he did not even purchase or stock.

(c) A meat vendor was found to be a shell company with no operations. The payments were divided between an administrator and the fictitious vendor.

(d) A vendor was accommodating enough to supply 'pro forma' invoices to an institution. The invoices turned out to be 'price quotations' as no goods had ever been shipped.

(e) An audit of one major vendor disclosed that several hospital employees were paid for such things as 'consultation' and 'commissions.' The employees were generally responsible for purchasing and stores.

(f) An audit of a drug supply house uncovered regular checks paid to a hospital's pharmacist. The vendor was found to be short-shipping (delivering less than the quantity billed and ordered).

(g) In one hospital, the purchase orders and receiving reports were often dated a few days after the invoice date for a particular vendor. During the course of the vendor audit, purchases of high priced items such as television sets, microwave ovens, and fur coats were noted. The vendor admitted giving these valuables as well as cash to hospital officials.

(h) One auditor became suspicious of a hospital which appeared to be purchasing the same medical supplies from three companies. One of the vendors was unknown to the auditor and an investigation was initiated. The audit disclosed an elaborate scheme of laundering funds through alleged suppliers of the vendor for the purpose of paying kickbacks to hospital personnel.

Section 4.2.2 - Auditing Procedures (Vendors)

(a) The auditor should assemble background information concerning the vendor by (1) reviewing the fraud control unit's central files; (2) obtaining a Dun and Bradstreet report; (3) examining bank credit files; and (4) obtaining information from governmental agencies (e.g., the Securities and Exchange Commission and Federal Trade Commission) for large publicly held vendors. Some background data may even be in the hospital's files.

(b) If the vendor has consented to an audit, interviews of the vendor and key employees, especially the bookkeeper, should be conducted to develop an overall picture of the operation. Ascertain the following:

(1) size and nature of the operation, (2) source of goods and services, (3) ownership of the business, affiliates, and subsidiaries, (4) number of employees, (5) business methods practiced (including rebate policy), and (6) financial and operating data, sales, purchases, gross profit, net income, and other pertinent information.

(c) If the audit is made at a location other than the vendor's place of business, a signed receipt detailing which records have been turned over should be prepared in duplicate, one copy for the vendor and one

copy for the fraud control unit. Missing items should be noted. The auditor should compare the inventory to the list of requested items or subpoena, and note non-delivery of any records.

(d) The auditor should review the general ledger. This will provide information concerning sales volume, capitalization, and gross and net profit. It will also enable the auditor to ascertain those accounts that may be used to hide the kickback (e.g., commission accounts, loan and exchange accounts, gifts to customers).

(e) Scan the disbursements books for any suspicious checks and checks issued and payable to (1) cash, (2) a principal, (3) hospital employees, (4) hospital special purpose funds, or (5) other persons (e.g., salespersons). Be alert for hidden bank accounts.

(f) Examine cancelled checks for checks payable to the payees listed in (e) and those checks bearing double endorsements. Particular attention should be made to concurrent payments by the hospital to the vendor and by the vendor to the payees listed in (e). Prepare a schedule of suspicious items, listing (1) date, (2) check number, (3) payee, (4) account charged, (5) amount, (6) endorsement, and (7) disposition (cashed or deposited, date, and the name and location of the bank).

(g) Examine the payroll for fictitious employees, padding or other devices which could be the means for siphoning off cash.

(1) Review payroll checks for names and endorsements and trace amounts to the payroll register at least on a test basis.

(2) Tie in gross payroll and payroll taxes for the year to the amounts reported on the Federal Forms 941 and W-2. Account for any differences.

(3) Determine if any employees were terminated recently and list them.

(4) Prepare a list of key employees especially salespersons and highly paid personnel. Obtain name, address, social security number, and annual gross pay.

(h) Review petty cash activity. Examine checks drawn and compare to journals and petty cash receipts. List exceptions. Summarize the petty cash activity if material.

(i) Review the vendor's order entry, shipping and billing records, if possible. Billing records which bear notations such as "dummy," "pro forma," often turn out to be fictitious invoices.

(j) Review the vendor's sales activity and reconcile it to the respective hospital's purchases. Match sales by vendor (accounts receivable) to purchases by hospital (accounts payable). List exceptions for investigation.

(k) Compare in detail the cash flow from the hospital to the vendor. Ascertain whether the total debits in the hospital's account payable ledger for cash payments or credits agree with the cash receipts and debits in the vendor's accounts receivable records. Be alert for unmatched rebates, discounts, and allowances. Detail differences for further investigation. Situations have been uncovered in which vendors failed to book fictitious invoices; when the cash was received, the payment was credited to "exchange" or "loan." A vendor check representing the kickback amount would then be drawn to clear the item.

(l) The auditor should examine the vendor's purchases to determine who the vendor buys from and in what quantities. A vendor may set up a fictitious supplier in order to funnel money out of the business. If the auditor suspects that one or more of the vendor's suppliers is a phony company, that should be investigated. The auditor should also keep in mind that the supplier might launder money as an accommodation to the vendor. Also, the auditor should be wary of suppliers operated by relatives or known associates of the vendor under examination. Vendors often insist they pay for purchases by checks payable to "Cash" because they have bad credit ratings or get a special deal; these should be documented and investigated thoroughly. The auditor should consider income tax implications.

(m) Request or subpoena the files of the vendor's outside accountant. Examine these records for evidence of improper entries, tax problems, questionable transactions or related parties.

Section 4.2.3 - Concluding the Vendor Audit

At the conclusion of the audit examination of a vendor's books and records, the auditor should prepare a report of the audit showing:

- (a) Vendor information (e.g., the vendor's bank accounts, who signs checks, sales volume),
- (b) Purpose of the audit,
- (c) The records that were audited, and
- (d) Findings and conclusions.

Section 4.3 - Payroll

Wages and salaries are the single largest expense of a hospital and, as such, there is a possibility of overlooking fraud in this area, if only because of the sheer volume of records. By being aware of the schemes that exist, the auditor's chance of finding fraud will be greatly enhanced.

Fraudulent practices in this area include:

- (a) Checks issued to fictitious employees,
- (b) Inflated amounts paid based on excessive rates of pay, unauthorized vacation time, or bonuses,
- (c) Amounts paid based on inflated hours,
- (d) Checks issued to terminated employees,
- (e) Checks issued to individuals who do not work for the hospital (e.g., a hospital officer's personal employees; a receptionist of a doctor-owner of hospital),
- (f) Misclassification of payroll cost in order to increase reimbursement (e.g., classifying outpatient clinic payroll to inpatient cost centers; charging non-reimbursable cost center payroll to reimbursable cost centers),

(g) Crediting an imprest payroll fund with excess funds that can be withdrawn by a payroll clerk (an imprest fund should be credited with a sufficient amount to cover the payroll; however, patients' receipts, purchase rebates, or any other source of funds can be diverted to the payroll account and subsequently withdrawn by payroll check).

If a payroll account has disbursements for expenses other than salaries (e.g., employee travel expense, educational expense), this is a possible fraud and should be scrutinized to ensure that these expenses are legitimate and not expensed elsewhere as well as through the payroll account.

The degree to which payroll is subject to an effective system of internal control determines the risk of fraud. The investigative auditor, therefore, must test the system in order to determine the nature and extent of the work required to be done in the payroll area. Careful attention should be given to the work of other auditors, such as internal auditors, independent auditors, or insurance fund auditors.

Section 4.3.1 - Internal Control - Objectives

The objectives of the payroll internal control system are to ensure that:

(a) Authorized amounts only are paid at approved rates to bona fide employees,

(b) Employees are paid only for time worked or authorized time off, and

(c) Clerical procedures are adequate for payroll calculation, timely recording, and proper classification.

The auditor should determine what policies and procedures are in effect and document them.

Section 4.3.1.1 - Internal Control - Examples of
Sound Practices

Examples of sound control practices to be considered:

(a) Separate independent personnel administration function,

(b) Complete personnel files with authorization for hiring, pay rates, and withholding,

(c) Separation of check signing function from personnel, payroll, recording function,

(d) Adequate accounting and control procedures for unclaimed pay,

(e) Time cards or other forms used to document hours worked,

(f) Surveillance and control of time clocks and cards,

(g) Periodic approval of time worked by supervisors on time cards or forms,

(h) Control of sick leave, vacation leave, holiday time, leave of absence and other time off,

(i) Separation of payroll preparation and distribution,

(j) Calculation of payroll directly from time cards or other reports,

(k) Independent checks of pay rates, time worked and deductions,

(l) Use of job descriptions, chart of accounts and department codes,

(m) Independent reconciliation of payroll cash accounts,

(n) Management review and control over overtime, bonuses, or other payments in excess of base compensation.

The auditor should document and evaluate the internal control in the payroll function.

Section 4.3.2 - Procedures for Auditing Payroll

These procedures are designed to indicate whether the system of internal control is being implemented effectively. This test will enable the auditor to determine the scope of further work required in this area. Consideration should be given to the work and findings in other audits. If the internal control is sound and the independent accountant's work corroborates this fact, testing in this area may be limited accordingly.

The detailed test procedures include:

(a) General ledger:

(1) Review the general ledger accounts for salaries and wages and related cash entries; note any unusual items for further investigation,

(2) Trace general ledger postings on a test basis to supporting documents and records.

(b) Select a sample of payroll transactions from the payroll register for further testing. This sample should be selected by the auditor on a judgment basis; it should be representative of the entire payroll.

Depending on prior findings and information, the auditor may wish to select certain items in order to concentrate on selected individuals or departments. Schedule the items selected - list such data as:

(1) Employee name,

(2) Employee clock or identification
number,

(3) Department,

(4) Payroll period,

(5) Gross salary, deductions, net pay,
and

(6) Payroll check number.

(c) Test the payroll register for selected periods:

(1) Check the accuracy of the footings,

(2) Trace the totals to the payroll summary
and check the accuracy, and

(3) Review the labor distribution to departments for accuracy and adequate support; trace distribution to the general ledger.

(d) Test the items selected in (b) (payroll register):

(1) Obtain employee personnel file and inspect for authorization for rates of pay, job description, proof that employee is a real person (picture and other vital data) and dates of hire and termination;

(2) Compare amounts paid, hours worked to time card or other record; note department worked, supervisor approval, overtime, and other factors, and

(3) Scan for arithmetic accuracy of gross pay, deductions, and net pay.

(e) Determine whether executive compensation is in compliance with board minutes, authorizations, and contracts. Inspect the supporting documentation.

(f) Examine the payroll bank reconciliations for at least two months to determine the effectiveness of internal control. Note any unusual items for further investigation.

(g) Inspect checks returned by the bank for items selected in the sample in (b) (payroll register). Examine endorsements carefully and compare to writing samples in the personnel folder. Note unusual endorsements such as those of out-of-town banks and multiple endorsers. Investigate these further to determine the validity of the payroll item. If compensation is paid in cash, signed vouchers or receipts should be available and inspected.

Section 4.3.3 - Special Procedures for Auditing Payroll

The following procedures should be carried out in conjunction with the detailed audit test procedures for payroll specified in Section 4.3.2:

(a) The auditor should bear in mind that one of the best sources of information is an interview with a terminated employee. As former insiders who may harbor resentment, they are often willing to shed light on activities that present employees will not discuss. Therefore, the auditor should prepare a list of key employees who have been terminated by the hospital. The last known address and information about the current employer should be noted by the auditor and given to the investigator.

(b) Because the audit usually concerns prior periods, the practice of witnessing a current payroll distribution would not necessarily disclose past irregularities. In addition, most hospitals operate on three shifts and a large number of employees are usually involved. Consequently, many employees would not be present to receive pay at any given time. If the past improprieties in certain areas or departments are suspected, a current head count of individuals actually at work in those areas could be made. Such a head count

might disclose a continuing practice of payroll padding. The results of the head count should be compared to time cards punched in, interviews of department staff, and staffing schedules, current payroll and employment records.

(c) If it was not done by other auditors, the payroll for each quarter of the year should be reconciled to the 941 quarterly federal payroll tax return, the quarterly state unemployment tax return, and the yearly 940 federal unemployment tax return.

(d) A check should be made to determine whether any terminated employees are currently receiving payroll checks. The auditor should review records of terminated employees (if such records exist) and compare to payrolls subsequent to termination dates. Such records include personnel files, notices to state unemployment insurance board, and notices to unions.

(e) Special attention should be given to personnel paid in cash, unless this is a common event, as for example, per a union contract.

(f) Many hospitals receive the services of volunteers. The auditor should ascertain the details concerning volunteers and check to see that volunteers do not appear on the payroll, or in any other account under a classification such as "consultants."

(g) A review should also be made to ascertain reasonableness of rates of pay. Excessive rates of pay may exist where there is a collusive agreement between an employee and a payroll clerk or manager to share the excess pay, or where an employee agrees to kickback excess pay to buy a job. A scheme may also exist to inflate payroll costs by excess pay (e.g., special lump sum or constant overtime payments) to an employee who then 'donates' the excess to a hospital fund. This results in an inflated cost for reimbursement purposes, where the donation is not offset against the expense and will not reduce the reimbursement rate.

(h) A payroll that is prepared on electronic data processing equipment presents special problems. A common scheme to be checked by the auditors is one which involves rounding down withholding taxes to the nearest dime. A payroll with a large number of employees each period can give rise to a large amount of rounding down. The amounts rounded down can be readily transferred in

the computer to any person designated in the program. The W-2 form of the transferee will have excessive withholding taxes which the transferee will receive from the government in the guise of a tax refund. The auditor should examine W-2 and W-4 forms for computer personnel in particular to ascertain if amounts of withholding appear to be excessive.

(i) W-2s should be examined to determine if federal, state, and local withholding taxes are realistic. The absence of local or state withholding taxes may flag a fraud, such as a fictitious employee on the payroll. The addresses on W-2s should also be checked. An out-of-town address may indicate a ghost on the payroll. W-2s returned by the Postal Service for inability to deliver should be carefully investigated; the employees named thereon may be fictitious.

Section 4.4 - Fiscal and Administrative Expenses

The performance of administrative, general, and fiscal services by and for the hospital are functions which pertain to the overall management of the institution. These are generally classified into the following groupings which may vary from hospital to hospital:

(a) Fiscal services:

- (1) General accounting,
- (2) Patient accounting,
- (3) Credit and collections,
- (4) Cashiering,
- (5) Admitting,
- (6) Emergency room registrations,
- (7) Other outpatient registrations.

(b) Administrative and general services:

- (1) Administrator's office,
- (2) Governing board expenses,
- (3) Public or community relations,
- (4) Personnel,
- (5) Communications,
- (6) Data processing,
- (7) Purchasing,
- (8) Receiving,
- (9) Medical records,

- (10) PSRO - Utilization Review,
- (11) Chaplains,
- (12) Nursing administration,
- (13) Fund raising,
- (14) Library,
- (15) Volunteers,
- (16) Management engineering.

(c) These accounts ultimately will be allocated to the routine service centers, ancillary service centers, and other cost centers including non-reimbursable cost centers. Aside from the objective of determining that these costs are bona fide and properly chargeable to patient care, the investigative auditor must examine any shifting of fiscal and administrative expenses to routine or ancillary cost centers. While these shifts are often perfectly proper and in keeping with acceptable practices, the potential for abuse exists. The auditor must review what was transferred, the rationale for the shift, and the statistical or other basis for the amounts transferred.

Section 4.4.1 - Examples of Fraudulent Practices
(Fiscal and Administrative Expenses)

(a) Executive director drawing additional compensation in excess of board authorized amounts.

(b) Data processing services performed off the books for other organizations.

(c) Personal legal expenses charged to the hospital.

(d) Including fund raising expenses in reimbursable costs.

(e) Burying direct, non-operating or non-reimbursable costs in administrative and general expenses.

(f) Offsetting cost recoveries to administrative and general instead of to the department to which they relate.

Section 4.4.2 - Audit Procedures for Reviewing Fiscal
and Administrative Expenses

(a) Preliminary review:

(1) Compare the provider's annual cost and statistical reports for this area. Note and investigate any unusual variation between periods.

(2) Compare the reported costs and statistics of this provider with group norms developed for this area (see Sec. 2.2.1). It may be helpful to develop statistics, such as cost per bed or cost per patient day for each year under review, in order to note unusual shifts of costs. In addition, the auditor may find it helpful to analyze the components of total cost (e.g., salary, other than salary) in the same manner, namely, per bed or per patient day.

(b) Discussions with administrative and financial personnel:

(1) Ascertain the functions and duties of each department in this section;

(2) Determine what costs are associated with non-reimbursable functions (e.g., managing real estate not used by the hospital, investment

activities chargeable to other funds, outside services) and how these costs are segregated;

(3) Determine if the costs of fiscal and administrative services are effectively controlled by a budget; and

(4) Discuss and obtain significant contracts for outside services such as data processing.

(c) Detailed Testing. The auditing procedures for purchases and payroll are contained respectively in Sections 4.1 and 4.3. If, in the auditor's judgment, exceptions or other circumstances warrant, extended procedures should be applied including the following:

(1) Examine the journal entries for large items near year-end; trace to supporting backup and determine propriety.

(2) Review professional fees (legal, accounting, other) by obtaining or preparing analyses and vouch these to invoices, statements. Be alert to items of a capital nature and non-reimbursable items such as certain planning costs and feasibility studies for abandoned projects,

personal type expenses, and other items not directly related to patient care.

(3) Investigate all direct allocations of expenses not disclosed on the cost report.

(4) Examine expenses for travel and entertainment, seminars, gifts, repairs and maintenance, if other auditors' work in these areas appears incomplete or unreliable.

(5) Vouch salaries of highly paid officials to authorization, board minutes, and other pertinent documentation. This may have been done as part of the payroll audit.

(6) Investigate any outside services performed by the hospital for others (e.g., data processing); determine if the amounts collected are reasonable and verify with outside sources. Verify that amounts paid by purchasers of hospital services have been properly recorded and offset.

Section 4.5 - Unassigned Expenses

"Unassigned expenses," as the term is used in the American Hospital Association's Chart of Accounts, comprise certain general expense classifications applicable to the hospital as a whole. These expenses are accumulated and distributed to other cost centers by means of statistical allocation, specific identification, or a combination of both. Unassigned expenses include:

- (a) Depreciation and amortization,
- (b) Leases and rentals,
- (c) Insurance (e.g., malpractice),
- (d) License fees and taxes (other than income taxes),
- (e) Interest (working capital, long term debt),
- (f) Employee benefits.

Section 4.5.1 - Depreciation and Amortization - Audit
Objective

These costs should be examined in conjunction with the work on property, plant, and equipment (see Part 6). The audit objective is to verify that depreciation expense is properly chargeable to patient care in accordance with the principles expressed in HIM-15, Chapter 1.

Section 4.5.1.1 - Examples of Fraudulent Practices
(Depreciation and Amortization)

(a) Asset lives arbitrarily changed to increase reimbursement.

(b) Assets counted or included twice for depreciation purposes.

(c) Depreciation on assets not actually used or no longer on hand charged to patient care.

Section 4.5.1.2 - Procedures for Auditing Depreciation
and Amortization

(a) Tie in the basis for the calculation of depreciation (e.g., cost) and reconcile to the books and supporting ledgers.

(b) Compare the amounts of depreciation between periods and investigate significant changes.

(c) Test the classification of assets from year to year; watch for changes in useful lives and investigate the propriety of such changes.

(d) Determine whether amounts not attributable to assets directly related to patient care are included for reimbursement purposes.

(e) Review adjustments to depreciation on the cost report and supplements for accuracy and propriety.

(f) Review any distribution of depreciation on the books; investigate the basis for the distribution and verify the computation.

(g) Review the statistical basis used for allocating depreciation for reasonableness, consistency.

Section 4.5.2 - Leases and Rentals

The audit procedures performed to test leases and rentals of real and personal property should be coordinated with the work on property, plant and equipment (see Part 6). Section 110 of HIM-15 concerning Medicare allowable costs discusses the treatment of cost in lease-purchase and sale-and-leaseback transactions. In examining leases and rentals, the investigative auditor must remember that the lessor is in effect merely a different type of vendor. The existence of a written lease is no assurance that the transaction is not fraudulent.

Section 4.5.2.1 - Leases and Rentals (Audit Objective)

The objective in auditing leases is to detect and document the existence of one or more of the following:

(a) Payment for, or booking the cost of fictitious assets, or assets not used in delivering patient care in the hospital.

(b) Undisclosed non-arm's length leases resulting in unlawful profits to the lessor and increased cost for reimbursement purposes.

(c) Purchases disguised as leases to accelerate write-offs, thereby increasing reimbursement.

(d) Rents inflated because of kickbacks to hospital personnel.

Section 4.5.2.2 - Examples of Fraudulent Practices
(Leases and Rentals)

(a) Prearranged abandonment by a lessor at the end of a lease, although the asset has a remaining useful life. Such a transaction indicates a purchase had taken place.

(b) Expensing capital purchases as rentals to obtain accelerated depreciation.

(c) Self-dealing in that assets are leased by parties in control at excessive rents.

(d) Inflated rents resulting from commissions or other expenses paid to officials of the hospital or their relatives by lessors or dealers.

(e) Leasing assets twice, or leasing assets that don't exist.

(f) Lease of assets that cannot be located on the hospital's premises.

(g) Unauthorized leases such as those for personal cars.

(h) Ordinary expenses disguised as capital lease rentals to avoid routine cost ceilings in reimbursement rate setting.

Section 4.5.2.3 - Procedures for Auditing Leases and
Rentals

(a) Examine the provider's cost reports and the certified financial statements for disclosure of leasing activity.

(b) Inquire of the administrator and the financial officer as to what leases the hospital has; request lists and copies of material leases.

(c) Review the general ledger and the books of original entry (cash disbursements, purchase journal) for evidence of leases-rentals; list and compare these to the lease documents obtained in (b). Note and investigate any significant discrepancies.

(d) Prepare or obtain an abstract of all material leases indicating the description of the item being leased. Note original cost, term of the lease, life of the asset, names of the vendor and lessor, rental payments, other terms such as options to renew or purchase, and whether the hospital is responsible for taxes, maintenance, insurance and other items.

(e) Ascertain whether the hospital has, in effect, purchased the items, that is, assumed all of the risks of ownership, guaranteed the lease, or leased for the entire useful life at rent that exceeds the original cost plus interest. If so, determine whether the accounting treatment is appropriate.

(f) Compare the list of major items leased to the property ledger; note any duplications of assets. Consider physical inspection of selected items.

(g) For little known lessors, or ones with post office box numbers as their addresses, obtain Dun and Bradstreet reports. If the auditor is suspicious of the lessor, a vendor audit should be done.

(h) Compare the invoice cost of the assets leased with similar items purchased; note any significant variances. Consider confirming details of the sale with original equipment manufacturer or dealer.

(i) For realty leases obtain a title search. Ascertain what relationship the owners/lessors have with the hospital; if a relationship exists, an acquisition cost audit should be done.

(j) If a bank is a party to a questionable lease, subpoena the bank's files; these files usually contain detailed information supplied by the lessor, lessee and the seller concerning the transaction. Compare this data with the hospital's books, records, and cost reports; note any significant discrepancies and investigate.

(k) Investigate recently expired leases; determine if the asset is being used currently by the hospital. If so, such use may be indicative of a purchase.

(l) Review donations and property ledgers for indication that the lessor donated this item to the hospital to be depreciated a second time at fair market value.

Section 4.5.3 - Insurance

This classification includes all types of insurance protection purchased by the hospital. The principal classes are professional malpractice, property insurance, and employee benefit insurance.

Section 4.5.3.1 - Audit Objectives (Insurance)

The objective of this aspect of the audit is to verify that the costs are proper and that they relate to the operations of the hospital. In addition, the auditor should determine whether all recoveries of expense have been properly reflected.

Section 4.5.3.2 - Examples of Fraudulent Practices

(Insurance)

(a) Insurance refunds, return premiums and claims are improperly credited to contributions, building funds and other inappropriate accounts resulting in failure to recover (reduce) costs for reimbursement purposes.

(b) Malpractice insurance costs for doctors' private practices are not recovered (offset) against allowable costs.

(c) Insurance costs paid or payable by hospital-based physicians under contract are not removed and consequently result in an overstatement of reimbursable costs.

(d) Insurance premiums not related to patient care (e.g., for items such as real estate holdings) are improperly included for reimbursement.

Section 4.5.3.3 - Procedures for Auditing Insurance

(a) Compare the general ledger accounts for the period under review for insurance expenses; note any significant variations.

(b) Obtain from the hospital files or the workpapers of the independent auditors the schedules in support of insurance expenses.

(c) Establish by examining these schedules and the policies the nature of the coverage the premiums, beneficiaries, the term of the policy, the identity of the property, and other pertinent data.

(d) Note for investigation the sources of the insurance (e.g., is the broker a board member; if so the cost may be inflated).

(e) Ascertain whether malpractice insurance covers all activities of the doctors practicing at the hospital (e.g., services to hospital patients as well as the doctors' private patients). If private practice is covered, do the doctors reimburse the hospital? Determine whether these costs have been identified and deducted from allowable costs from reimbursement purposes.

(f) Ascertain whether any property not used for operating purposes is included in the coverage. Determine whether these costs have been identified and deducted from allowable costs for reimbursement purposes.

(g) Determine whether employee benefit coverage for executives has been approved by the board and is reasonable. Are any non-employees covered? If so, investigate this situation.

(h) If the hospital is self-insured, does the insurance program meet the standards outlined in Sec. 2162 of HIM-15?

Section 4.5.4 - License Fees and Taxes

This classification consists of all professional and business licenses and taxes (other than income tax) necessary to conduct a hospital operation. The auditor should determine that the amounts are reasonable in total and that they do not include non-allowable items such as the costs associated with carrying on an unrelated trade or business.

Section 4.5.5 - Interest Expense

According to HIM-15, Sec. 200, in order for interest expense to be allowable it must be both necessary to the provider's operation and proper with respect to the rate and other terms. Interest is classified into short-term (operating cost) and long-term (capital component cost). In proprietary establishments, special care must be taken in this area, because borrowing and related interest expense could be used to cover an owner's withdrawals of capital which is not recognized as a necessary purpose.

Section 4.5.5.1 - Examples of Fraudulent Practices -
(Interest Expense)

(a) In a proprietary establishment, bank financing was the source of funds used to buy out withdrawing partners. The interest was improperly included in the provider's statement of reimbursable costs.

(b) A hospital transferred liquid assets from the unrestricted fund to a building fund where they were invested. No offset to the unrestricted fund's interest costs was made for the investment income resulting from the transferred assets.

(c) Interest expense was incurred to finance acquisition of property, part to be used for patient care and part for other business. No allocation of interest was made.

(d) Operating interest charges were classified as capital interest to avoid routine operating cost ceilings.

(e) Construction-related interest was expensed to operations instead of being capitalized.

Section 4.5.5.2 - Procedures for Auditing Interest
Expense

(a) Review the provider's cost reports and financial statements for disclosure of borrowing and related interest changes. Establish the need for borrowing and investigate the use of loan proceeds; statements of change in financial position and cash flow statements should be used for this purpose.

(b) Examine the general ledger accounts for interest expense; vouch the interest expense by examining cancelled checks, advices, and other documents. Compare rates of interest to market conditions. Other auditors' workpapers may be used in order to avoid duplication of effort.

(c) Examine loan documents, compare to payments, ascertain the identity of the lender and whether any questionable relationship exists; if so, investigate the consideration for the transactions and the propriety of the interest charge. For proprietary facilities, interest charges on loans by owners are not allowable.

(d) Check the calculations of interest charges; verify that each fiscal period is charged only with its pro-rata share of expense.

(e) Determine whether interest accounts include penalties or fines for late payments of taxes and other obligations; if these are attributable to negligence or deliberate acts by the provider, such charges may not be reimbursable.

(f) Ascertain that all applicable cost recoveries (e.g., offsetting investment income against interest expense) have been recorded properly.

(g) Ascertain that applicable state limitations on interest on capital debt are properly implemented in the rate calculation process.

(h) Investigate any direct allocation of interest to patient cost centers.

Section 4.6 - Employee Benefits

These expenses include payroll related employee benefits such as FICA, pension and retirement costs, health benefits, and union benefits. These costs may be accumulated in a separate cost center for distribution in the cost finding process, or they may be distributed directly to appropriate cost centers periodically in the providers accounting records.

Section 4.6.1 - Examples of Fraudulent Practices
(Employee Benefits)

(a) Including the cost of benefits payable to relatives, friends or domestic help in reimbursable costs.

(b) Failing to disclose the inclusion of costs relating to non-reimbursable activities or services.

(c) Reporting inflated costs of benefits never intended to be paid, thus increasing reimbursement.

Section 4.6.2 - Procedures for Auditing Employee
Benefits

(a) Compare the provider's cost reports for employee benefits for the periods under review. Investigate any significant variations in specific costs between periods.

(b) Review the general ledger accounts for the periods under review to determine the nature and amount of the expense.

(c) Ascertain whether accruals have been paid within reasonable time periods. Pension costs are required to be funded within 75 days after the end of the fiscal year (see HIM-15, Chapter 21).

(d) Test the amounts included in expenses by reviewing the underlying agreements and documents. Prove overall calculations and check computation of detailed entries (e.g., FICA can be checked by totaling the year's 941 forms, adding the year end accrual and subtracting the corresponding prior year accrual).

(e) In proprietary facilities, determine whether fringes or pension plans discriminate in favor of highly paid employees such as the owner, operator, or administrator.

(f) Ascertain by comparing invoices, list of beneficiaries, or similar documents to the audited payrolls that benefits are only incurred for bona fide employees engaged in delivery of patient care.

(g) Determine whether doctors' fringes have been considered in computing the professional component exclusion for Medicare Part B.

(h) Determine whether the costs associated with non-reimbursable activities have been properly recognized for cost finding purposes (e.g., non-related real estate operations, gift shops, or research projects).

PART V : REVENUE CYCLE AUDIT GUIDES

Section 5 - Audit Guides for the Revenue Cycle

The revenue cycle is the process for recognizing, measuring, and classifying revenue in the records of the hospital. The patient service revenue cycle begins with the pre-admission interview and ends with the recording of the cash received in final settlement of the hospital's claim for service.

The cycle of revenue accounting -- patient accounts, cash receipts, credit and collections -- is one of the most complex areas confronting hospital financial management. The great volume of transactions, intricate charge structures, varied and overlapping coverages by third parties, coupled with complicated billing requirements, the amount of paperwork and the number of people who must process it, all contribute to making this area a most difficult one for the investigative auditor. The stages in the revenue cycle are common to most hospitals; however, there is much diversity in the types of systems, forms, and procedures.

Section 5.1 - Revenue Cycle - Audit Objectives

The objective of this phase of the audit is to determine the existence and extent of fraud in the cycle of revenue accounting. The question is whether the hospital is billing, receiving, and recording properly the funds to which it is entitled for services rendered. The investigative auditor should not attempt to perform a financial audit, or merely duplicate the work done by the hospital's independent accountant.

Section 5.2 - Admissions

Hospitals generally maintain a separate admitting department where the initial contact with the patient is made. This department should have defined policies and procedures governing admissions and the gathering of pertinent personal and financial data about the patient.

Outpatients are usually processed at a registration desk, but in some hospitals outpatient registrations are processed in each service area. The type of register or other control over outpatient services varies from one hospital to another. Outpatients can be charged on a cash fee-for-service basis, as well as on credit billing and third-party billing.

The auditor should coordinate the work on outpatients with the work on inpatients because there are services (e.g., radiology, laboratory) that are used by both classes of patients. Also, it is necessary to determine whether charges are uniform for both inpatients and outpatients.

The auditor should document and evaluate the policies and procedures in use. Special attention should be given to admissions through the emergency room because this could be an area of abuse in that same-day utilization review can be bypassed. Also, inpatient admissions can be increased by unnecessary admissions through the emergency room. In addition, the shift of routine costs from the emergency room to the inpatient area could result in over-reimbursement.

Section 5.2.1 - Internal Control - Admissions

The following are sound internal control features to be considered in reviewing the procedures in effect in the admitting department:

(a) Maintenance of permanent patient register with record of all admissions, patient identification, and discharge date.

(b) Use of hospital admitting control numbers.

(c) Prenumbered admission forms, a copy of which triggers the establishment of a patient's account and medical record.

(d) Documentation of all third-party coverage and other sources of payment.

(e) Effective control over pre-admission deposits.

Section 5.2.2 - Test of Charges

The most significant detailed primary test to be performed during the hospital audit is the test of charges. The terms charges as used in hospitals means the claims (generally to receive cash) arising as a result of providing services to patients. For example, when a patient has a lab test, a charge ticket is prepared by the lab and forwarded to the billing section. The charge ticket triggers the recording of an increase (debit) to the patient's account receivable and a corresponding increase (credit) to the hospital's revenue account at the value or price established by the hospital for the service. The charge mechanism, therefore, is the basis of the hospital's patient revenues.

Charges and revenues have great significance to the hospital, both in the usual financial sense and for third-party reimbursement purposes. The significance of revenue to the financial well-being of the facility can be appreciated in terms of its reimbursement impact. Medicare settlement for ancillary services is based on the ratio of Medicare charges to all charges applied to costs (the RCCAC method of apportionment). This requires that hospitals adopt uniform charge (pricing) structures and maintain accurate compilations of Medicare charges,

as well as total patient charges by each service center. Some third-party payors reimburse the hospital on the basis of charges, that is, the total of the value of the services actually rendered to the patient at the hospital's established prices. This requires hospitals to maintain a system of pricing services at established rates and recording the information in the accounts accurately. Since many patient bills are paid by third parties which have negotiated settlement rates lower than the hospital's full charges, the hospital must have good systems in place to capture, record and report charges (revenues) in order to plan and budget effectively. Some third-party payors require cost allocations (between inpatient and outpatient or covered and non-covered services) based on revenue or statistics; this requires accurate compilations of departmental revenues based on actual patient charges.

The expanded charge test is an effective method for determining whether the hospital is properly charging and billing patients for all services rendered. To avoid duplication of effort, a thorough examination of other auditors' workpapers regarding this test should be made in order to determine which procedures have been adequately audited and to identify problem areas. For example, if the hospital's independent accountant has

performed extensive tests of radiology charges, the auditor may decide to do limited work in this area.

The expanded charge test will be used to examine the following:

(a) Patient billing:

(1) Accumulation of charges,

(2) Accounts receivable,

(3) Allowance and receivable write-offs, and

(4) Patient eligibility for benefits.

(b) The recording and handling of cash receipts.

(c) Ancillary service areas:

(1) Verification of department procedures,

(2) Accuracy of departmental records (e.g., log books),

(3) Testing of hospital-based physician financial arrangements and billing practices (see Sec. 5.6), and

(d) Accumulation of patient service statistics.

Section 5.2.3 - Selecting the Sample for the Test
of Charges

This test requires the use of a judgmental sample sufficiently large to encompass all aspects of revenue generating operations. The sample should include both inpatients and outpatients. Sample size depends on such factors as the size of the hospital and the range of services provided. The sample should be large enough to encompass the full range of patient services provided. At minimum, 30 inpatients, 10 outpatient clinic and 10 emergency room patients should be selected for testing. If the case mix warrants, at least one-half of inpatient selections should come from the surgical service. The remaining inpatient selections should be representative of a cross-section of medical, pediatric, maternity, psychiatric, intensive care and coronary-care patients. The outpatient clinic selections should also be representative of the different types of clinic services available.

Other factors to consider in determining the sample are:

- (a) Age and sex of patients selected should be representative of the hospital population as a whole (if known).

(b) Specialties (e.g., hospital has large neurosurgical department) should be considered.

(c) Sample should include a limited number of length-of-stay extremes, that is, abnormally short and long stays.

(d) Date, time and source of admission should be varied to include weekend, nighttime, private patients, and emergency room admissions.

(e) The sample should be in proportion to the hospital's pay class mix; Medicare, Medicaid, Blue Cross, self-pay and commercially insured patients should be represented. This factor should be modified if the auditor's objective is to review certain pay classes only.

(f) If there are specific allegations of alleged wrongdoing, the auditor should attempt to verify those allegations during the charge test.

The inpatient sample must be taken from the hospital's admission register. The admission register is used because it generally contains expanded information required for selecting the sample, and the auditor is trying to determine if there are income omissions. Outpatient selection should be drawn from whatever control source is maintained (e.g., registers, department logs, medical records).

Section 5.2.4 - Test Documents (Test of Charges)

The following documents will be required to be reviewed to complete the test of charges:

(a) Admission and discharge register (emergency room log, outpatient clinic registers),

(b) Patient account ledger,

(c) Patient billing folder (charge slips, billing forms, third-party reports of eligibility, and other applicable documents),

(d) Patient medical record,

(e) Daily census report,

(f) Standard pricing (charge) sheet,

(g) Ancillary department logs,

(h) Cash receipts journal and supporting documentation, and

(i) Third-party payment advices.

Section 5.2.5 - Audit Procedures for Test of Charges

The following are the audit procedures for the test of charges:

(a) Select sample (see Sec. 5.2.3).

(b) Record the following information from the patient's admission and billing records on a worksheet:

(1) Patient's name,

(2) Hospital or admission number,

(3) Pay class,

(4) Accommodation (private, semi-private),

(5) Date admitted/discharged,

(6) Length-of-stay,

(7) Total charges to patient,

(8) Room and board charges,

(9) Details of ancillary and other charges (e.g., operating room, anesthesia, recovery room, laboratory, radiology).

(c) Trace the patient's name to the daily census report and discharge register, making certain the patient was not charged for the day of discharge.

(d) Verify room and board charges by multiplying the patient days by the room rate, as per the standard pricing sheet.

(e) For ancillary service charges:

(1) Verify through the review of the patient's medical record that services were actually performed as ordered;

(2) Verify pricing of charge slips to hospital pricing sheet;

(3) Trace charges to departmental logs and other applicable documents; select a representative sample of charges from ancillary department logs and trace in detail to the medical records, the billing records and the revenue or income journal to ensure

that all services performed are being billed properly and the income is recorded on the hospitals books in a reasonable manner;

(4) Review on a limited basis and test reasonableness of daily charges from pharmacy, central supply, medical supplies, and oxygen.

(f) For surgical charges:

(1) Verify operating room and, if applicable, recovery room time by comparison to logs and medical records.

(2) Perform a test of reasonableness for operating room and anesthesia supplies.

(g) Make an overall review of the patient's medical record noting any discrepancies between the record and the bill.

(h) Trace ancillary service and other charges billed to applicable charge or income journal.

(i) Examine patient claim form and compare with patient ledger account and billing file:

(1) For Medicare patients, examine the Report of Eligibility and verify that proper adjustments were made for deductibles and co-insurance amounts;

(2) For Medicare and other third-party payors, examine approvals and related documentation.

(j) Verify receipt of payment through examination of cash receipts book and remittance documentation from third parties, self-pay patients and insurance; if possible, trace the receipt to the bank deposit slip.

(k) Determine whether allowances were properly recorded.

(l) Review the supporting documentation for credits to patient's account.

(m) Determine whether a reasonable effort was made to collect receivables and review the propriety of write-offs.

(n) Examine patient's ledger account and billing file for evidence of multiple billing (e.g., credit balances) and investigate.

(o) Perform other tests necessary to clear exceptions noted in earlier procedural reviews, or to prove or disprove allegations (e.g., direct confirmation or services rendered, dates of service).

Section 5.3 - Billing (Accounts Receivable)

The billing process consists of accumulating on a daily basis all charges for room and board and professional services to patients, pricing, recording this data in the income journal, and posting the amounts to the individual patient account cards. Room and board charges usually are prepared from daily census reports originating from the admitting department. These are compared to daily census forms prepared in the nursing service departments. Professional service charges are typically generated by prenumbered charge tickets prepared in the service departments and transmitted to the accounting department. Bills are submitted periodically to the parties responsible for payment.

Particular attention should be given to the practices of the hospital where dual and overlapping coverage occurs. Patients often have dual or overlapping coverage (e.g., both spouses work and each is covered by the other's policy, or an indigent person over 65 has both Medicare and Medicaid coverage). In such situations, the hospital is required to obtain all coverage information from the patient and disclose it on the billing or claim form submitted to each third-party payor. Patients may be asked to assign insurance benefits to the hospital at the

time of admission. There have been occurrences where a hospital has failed to disclose other coverage on the billing form, with the result that the hospital was paid more than it was lawfully entitled to receive for the services provided.

Under the coordination of benefits clause found in many health insurance policies, if dual coverage exists, one of the carriers is determined to be the primary carrier and pays the claim up to the limit of its policy; the other carrier is a secondary carrier and pays the balance (if any) of the claim up to the limit of that policy. The purpose of the coordination of benefits provision is to prevent someone from profiting from an illness by being paid more than the expenses actually incurred. Medicare is usually considered a primary carrier. Medicaid is always considered a secondary carrier. The investigative auditor should be aware that when a hospital receives payments in excess of the hospital's lawful claim from third-party payors and retains these funds, the funds either belong to a carrier, the patient, Medicaid, or Medicare. Such situations may be detected by reviewing the patient accounts receivables and noting significant credit balances. These in turn should be analyzed to determine their source and disposition. Significant write-offs of patient credit balances should be

investigated thoroughly. Questions of ownership of the excess payments will have to be determined after considering the applicable law in each case.

An understanding of the particular billing requirements of Medicare, Medicaid, and other third parties should be obtained by the auditor beforehand by studying the applicable regulations and provider instructions. Medicare billing instructions and forms are explained in HIM-10, Chapter IV. Medicaid billing forms and instructions can be obtained from the single state agency administering the Medicaid program, or from the local social service district or its equivalent. Other third-party payor forms and instructions can be obtained from the carriers. Hospitals should also maintain files of forms and instructions which are issued regularly by the various third-party payors.

The auditor should review, document, and evaluate the policies and procedures by interviewing personnel and observing procedures and documents used.

Section 5.3.1 - Internal Control (Billing)

The following are sound internal control features to be considered in reviewing the procedures in effect in the billing department:

(a) Use of daily census reports listing all patients and accomodations,

(b) Written notices of admissions and discharges routed to billing department,

(c) Standard published rates and prices (charges),

(d) Periodic reconciliation of revenue to occupancy records,

(e) Periodic reconciliation of professional service charge tickets to service department, logs, registers,

(f) Prenumbered charge tickets containing patient name and hospital or admission number,

(g) Supervisory review of pricing and posting of charges to patient accounts,

(h) Use of control accounts and reconciliation to accounts receivable detail,

(i) Authorization and control over payments of credit balances,

(j) Maintenance of fully documented individual patient billing file jackets with complete billing history, cash collection data, and other information,

(k) Internal audit, including direct confirmation of account balances, and

(l) Separation of duties and rotation of personnel.

Section 5.3.2 - Examples of Fraudulent Practices (Billing)

(a) Billing for days in excess of stay resulting from failure to compare bills to census reports and discharge notices.

(b) Failure to report charges or cash receipts by omitting service patients, and failure to reconcile census counts to reports.

(c) Theft or loss of cash resulting from the failure to separate the cash handling function from the patient accounting function.

(d) Missing charge tickets or inadequate audit trails conducive to billing for services not rendered.

(e) Discriminatory charging practices for Medicare or private insurance cases resulting from a lack of a uniform charge structure.

(f) Embezzlement of cash concealed by destruction of patient account cards, or deliberate misposting to patient accounts cards. Comparison of revenue and collection totals, and reconciling detail ledgers to control accounts on a regular basis would aid in the detection of such an embezzlement.

(g) Misapplication of refund checks resulting from poor control over authorizations and supervisory failure to review accounts.

(h) Misclassification of patients by class of payment (e.g., classifying self-pay as Blue Cross) can enable the diversion of the cash difference between charges.

(i) Ineffective accounting controls over outpatient, emergency room, or clinic services can result in cash being diverted by hospital personnel.

(j) Overbilling resulting from poorly documented policies or procedures, lack of training, or inadequate supervision.

(k) Improperly billing for newborn nursery at the full inpatient rate instead of the one-third rate for well babies (if applicable).

(l) Improperly billing psychiatric inpatient days when patient was absent or on leave.

(m) Multiple billing for clinic services to the same patient on the same day (if applicable).

(n) Multiple billing to third-party payors for the same services, failure to identify coordination of benefits and collecting and retaining excess payments.

Section 5.4 - Cash Receipts

The cash receipts function is divided generally into two categories: mail receipts and over-the-counter receipts. This function is, by its nature, a high risk area.

The auditor should review, document, and evaluate the policies and procedures by interviewing personnel and observing procedures and documents used.

Section 5.4.1 - Internal Control (Cash Receipts)

The following are sound internal control features to be considered in reviewing the cash receipts function:

(a) Incoming mail is opened and receipts listed and recorded by persons other than accounting department staff.

(b) Use of lists of mail receipts to record credits to patient accounts and to cash journal; retention of these lists as well as supporting documents such as payment advices.

(c) Separation of cash handling from patient accounts functions.

(d) Separate accountability and reporting for each cash fund location; vesting of responsibility for each fund in designated persons.

(e) Cashier area physically secure.

(f) Strict use of prenumbered or cash register receipts for over-the-counter cash; follow-up controls in this area.

(g) Daily deposit of receipts intact, prompt recording in a cash receipts journal or register.

(h) Periodic rotation of employees.

Section 5.5 - Allowances - Contractual and Other

Since revenue is generally recorded on the accrual basis (when services are rendered) and on a full charge basis, the hospital is required to record differences between full charges and amounts actually collected or collectible as a credit to the patient accounts and as an offset to hospital gross revenues. The most frequently encountered types of allowances are:

(a) Contractual allowance is the difference between the full hospital charge -- net of co-insurance and deductibles chargeable to the patient -- and the contractual reimbursement. The contractual allowance is determined on the basis of classification of patient by payor.

(b) Charity allowance is the difference between the full charges and the amount received or receivable from an indigent patient.

(c) Courtesy discounts granted to employees, clergy, or others having a special relationship to the hospital.

(d) Bad debt allowance is the unpaid balance of the full charge arising from uncollectibility for reasons other than inability to pay.

The auditor should document and evaluate the policies and procedures by interviewing personnel and observing procedures and documents used.

Section 5.5.1 - Internal Control (Allowances - Contractual
and Other)

The following are sound internal control features which should be considered in reviewing allowances.

(a) Documentation of all allowance adjustments with verifiable audit trails.

(b) Special authorization by responsible officials for allowances other than contractual allowances.

(c) Independent review and check of allowances by responsible officials.

Section 5.5.2 - Examples of Fraudulent Practices
(Allowances - Contractual and Other)

(a) Improper classification of a patient (e.g., classifying a private-pay patient as a Medicaid or Blue Cross patient) can result in a theft of part or all the payments received by an amount equal to the difference between the allowances of the respective pay classes involved.

(b) The recording of unauthorized courtesy or charitable allowances can be an indication of theft or loss of cash.

(c) The write-off of a credit balance in a patient's account resulting from collections from multiple payors and the crediting of an allowance account can be an indication of theft of the overpayment.

Section 5.6 - Credit and Collections

If patient or third-party payor, or both, fails to pay part or all of the account receivable, the hospital usually will undertake collection efforts to recover the balance due. The collection function should be independent from the billing and cash receipts functions.

The auditor should review and evaluate the policies and procedures by interviewing personnel and observing procedures and documents used.

Section 5.6.1 - Internal Control (Credit and Collections)

The following are sound internal control features that should be considered in reviewing credit and collections.

(a) Authorization by responsible officials for non-cash credits to accounts receivable,

(b) Segregation of accounts receivable from cash receipts functions,

(c) Review and proof of contractual allowances,

(d) Maintenance of adequate records of collection efforts,

(e) Maintenance of records of accounts written off, and

(f) Issuance to management of periodic aged trial balances of receivables.

Section 5.6.2 - Examples of Fraudulent Practices
(Credit and Collections)

(a) Premature write-off of accounts with subsequent collection by employees or others.

(b) Unauthorized credits for accounts receivable to conceal lapping or other defalcations.

(c) Diversion of cash from accounts written off, especially if no record is kept of such accounts.

(d) Turning over good accounts to collection agencies and division of collection fees between the collection agency and hospital employees.

Section 5.7 - Audit Guide for Revenue Centers (Ancillary Centers)

A revenue center is a department of the hospital that regularly generates separate charges to patients for the provision of services ancillary to routine inpatient and outpatient care. Typical ancillary services include diagnostic and therapeutic radiology, laboratory, electrocardiography, anesthesiology, occupational and physical therapy, respiratory therapy, and operating, recovery and delivery rooms. The following is a detailed discussion of the audit procedures for two typical ancillary service departments: radiology and laboratory. These procedures, with certain modifications, should be equally applicable to other ancillary service departments in the hospital. Also included are examples of fraudulent practices in other ancillary service departments.

Although ancillary service departments are under the general control of the administrator, many ancillary services are directed by physicians. In reviewing ancillary service centers, the investigative auditor must gather information about the operation of the department, including:

(a) The relationship of the physician-director with the hospital. Is the physician an employee or an owner?

(b) The financial arrangement between the hospital and the physician-director. Is the compensation salary, or based on volume of services, or gross or net billings? Does the physician donate or return any portion of compensation to the hospital?

(c) Does the physician-director bill hospital patients directly or indirectly on a fee-for-service basis? Is there a risk of double billing?

(d) Does the physician-director have an interest in a competing service outside the hospital? What hospital business is done at the outside facility?

(e) Does the physician-director utilize the facilities, staff, or property of the hospital for private practice? If so, is the hospital identifying and recovering the costs associated with the physician's services to non-provider patients?

Section 5.7.1 - Audit Guide for Radiology

This department provides under the direction of a radiologist diagnostic and therapeutic radiology services for the examination and treatment of patients. Activities include taking and developing X-rays, fluorographs, sonograms and tomography scans; examining and interpreting test results; consultations with attending physicians; storing and retrieving films; and the disposal of radioactive waste, used film, and developing solution.

Sources of revenue include billing by the hospital based on departmental rate schedules; rent received from radiologist under lease arrangement (physician usually does the billing); silver reclamation; research grants; and tuition for training technicians. Direct expenses usually include salaries and wages, physician compensation, cost of equipment rental, film and supplies, and repairs and maintenance.

Section 5.7.2 - Examples of Fraudulent Practices (Radiology)

(a) The hospital pays the radiologist's professional service component and this cost is included in the hospital's per diem reimbursement rate. If the hospital or the radiologist bills separately for the professional component there is double billing - first through the hospital's per diem rate, and second by the separate billing to the patient or third party.

(b) If the radiologist uses the hospital facilities for private practice (i.e., services to non provider patients), the costs associated with the private practice should not be included as allowable costs for reimbursement purposes.

(c) Used X-ray film and development solutions contain silver which can be reclaimed. Revenues from sales of used film and solutions should be offset against departmental costs at the least. Frequently, such revenues are misrecorded in a restricted fund, offset against costs of a non-reimbursable cost center, or simply stolen by dishonest employees.

(d) Kickbacks on purchases of equipment and supplies increase reimbursable costs.

(e) Billing third-party payors for noncovered services such as routine physical examinations, or billing for services not rendered.

(f) Theft of equipment and supplies by departmental personnel.

Section 5.7.3 - Audit Procedures - (Radiology Department):
Preliminary Review

Before communicating with departmental personnel, the auditor should review the provider's cost reports and related statistical data in the following manner:

(a) Review the cost reports submitted by the hospital for the periods under review. Note significant fluctuations in costs or statistics for radiology between periods. Consider:

(1) Cost per procedure (e.g., salaries, other costs, total),

(2) Number of procedures per full-time equivalent,

(3) Ratio of films to procedures,

(4) Cost of interpretation per procedure, and

(5) Approximate number of procedures per 100 beds and per admission.

(b) Review Hospital Questionnaire (see Investigative Manual, Appendix A) for vendors supplying this department:

(1) Examine for reasonableness of department purchases, and

(2) Note and investigate if more than one vendor is supplying the same goods or service to the department, if the vendor is small or unknown, or if the vendor uses an address such as a residence or post office box number.

(c) Obtain and examine the documentation concerning the financial arrangements between the hospital and the physicians. Note major points, such as duties, amount of compensation, restriction on outside activities, permission to carry on private practice on hospital premises, and fringe benefits.

(d) Review the hospital's operations manual for information about the types of services rendered in the department, special services such as nuclear medicine and cobalt therapy, persons responsible for rendering these services and how they are compensated, and the person responsible for day-to-day operations.

Section 5.7.4 - Audit Procedures (Radiology Department)
Interviews with Key Personnel

(a) The auditor should discuss the functions of the department with the person responsible for day-to-day operations. The information to be obtained includes:

(1) What logs are maintained, what is contained in the logs, and what information is entered therein.

(2) How are X-ray request forms and charge slips processed, and what information do they contain, what are the billing procedures?

(3) What are the procedures for requesting tests for different types of patients (e.g., inpatient, outpatient, referred ambulatory)? Are tests specifically ordered or are they done on a routine basis?

(4) How and by whom are cost finding statistics compiled? Are the statistics reasonable?

(5) Is any work done without charge or for a reduced charge?

(6) To what extent are outside services such as mobile scans or patient referrals to other institutions utilized? Identify the outside providers rendering such services. Determine contractual and billing arrangements for these outside services.

(7) With respect to silver reclamation from used X-ray film and solutions, identify the person responsible for this function and review the pertinent records. Determine whether recovery is reasonable and consistent with usage.

(8) Do any employees work for outside services, the radiologists?

(b) Identify the person responsible for selection of vendors and purchasing. Ask the chief technician's opinion of the quality and price of the materials used in the department. Inquire whether competitive prices are obtained.

(c) Determine ownership (by hospital or other person) of equipment; inquire about details of leases (from hospital to physician, from third party to hospital or physician), rental purchase options, and service contracts for repairs and maintenance.

(d) In concluding this phase of the interview, the auditor should inquire about problems existing in the department, knowledge of improprieties, and about other matters that require explanation.

(e) The auditor should then discuss the functions of the department with the radiologists to determine the details of the financial arrangements between the hospital and the physicians and nature and extent of their practice in and outside of the hospital. Items to be covered include: private practice, especially that conducted on hospital premises; the types and volume of procedures performed; billing practices; administrative duties, including service on hospital committees; involvement in the purchase of equipment and supplies; and other matters that require disclosure and explanation.

Section 5.7.5 - Detailed Audit Procedures - Radiology
Department

(a) The log book should be examined in conjunction with the test of charges. The purpose of the review is to identify an abnormally large number of specific tests, absence of certain tests, and the reasonableness of entries. Log book entries for patients selected in the charge test should be reconciled to charge slips, medical records, and patient account cards. In addition, a sample of entries in the log should be traced to patient billing and the income journal to ascertain whether all procedures are being billed properly. The auditor should test the reasonableness of the compensation paid to the radiologist, if based on percentage or related to volume, or the number of procedures and films taken (statistics reported).

(b) With respect to silver recovery, the auditor should test the reasonableness of recoveries. Used (black) film recovery should also be verified. Trace recoveries to cash receipts record and examine recovery offset to expense; recoveries should not be reported as income but as a credit to departmental expenses.

(c) A detailed review of purchases by this department should be made as follows:

(1) Review the general ledger accounts for the source and volume of purchases,

(2) Trace general ledger entries to sources and review (e.g., purchase journal),

(3) Examine invoices, purchase orders and receiving documents, as well as other evidentiary matter in support of original entries in the purchase journal or other book of original entry, on a test basis, and

(4) Schedule discrepancies and irregularities for further investigation.

Section 5.8.1 - Audit Guide for Laboratory

The laboratory area of a hospital performs clinical, pathological, and routine evaluations of patients specimens under the direction of a physician. The clinical labs include chemistry, hematology, immunology, microbiology, and urology. Pathology labs include cytology, histology, and autopsy.

Laboratory functions include but are not limited to, transporting specimens from nursing floor and operating rooms; drawing blood samples; caring for lab animals and equipment; maintenance of quality control standards; operation of mortuary; and preparing samples for testing.

Patients are charged on a per procedure or per test basis. Expenses generally included in Laboratory are salaries and wages, professional fees, supplies, purchased outside lab services, and rental payments.

Section 5.8.2 - Examples of Possible Fraudulent Practices
(Laboratory)

(a) Private practice tests being performed by hospital staff using hospital equipment with no recovery and offset against lab cost by the hospital.

(b) Performing several simultaneous lab tests on automated equipment and billing each as an individual test.

(c) Doing more tests than those ordered by physicians.

(d) Billing for tests not performed.

(e) Billing by outside lab and the hospital for the same tests.

(f) Performing unnecessary sensitivity tests when cultures are negative.

(g) Kickbacks on purchases of equipment and supplies giving rise to increased reimbursable costs.

Section 5.8.3 - Audit Procedures (Laboratory)

Preliminary Review

Before communicating with departmental personnel, the auditor should review the provider's cost reports and statistical data as follows:

(a) Review the cost reports of the provider for periods under examination for laboratory costs and statistics. Note significant variances in cost or statistics for investigation. Consider:

- (1) Cost per test (e.g., salary/other/total),
- (2) Number of procedures per full-time equivalent,
- (3) Cost per procedure or test,
- (4) Number of tests per admission and per 100 beds.

(b) Review Hospital Questionnaire (see Investigative Manual, Appendix A) for laboratory related vendors:

(1) Examine for reasonableness of purchases,

(2) Note and investigate suspicious vendors, (e.g., more than one vendor supplying the same goods and services; vendor is small or unknown; or vendor uses an address such as a residence or a post office box number).

(c) Obtain and examine the documentation concerning the financial arrangement with the physicians. Note terms of contract with regard to duties, compensation, restriction on outside activities, permission to use hospital premises for private practice, and fringe benefits.

Section 5.8.4 - Audit Procedures (Laboratory)

Interviews with Key Personnel

(a) The auditor should discuss the functions of the department with the person responsible for day to day operations. The information to be obtained includes:

(1) What logs are maintained, what information is contained in the log and who enters it.

(2) How statistics are compiled. What assurances are there that the logs are accurate?

(3) How laboratory request and charge forms are processed, what information do they contain and what are the billing procedures?

(4) What are the procedures for requesting tests for different types of patients (e.g., inpatients, outpatients, private patients). Are tests specifically ordered or done on a routine basis?

(5) Review other contracts if significant; review equipment leases and service contracts for future reference.

(6) How are repeated tests charged?

(7) Are any labs tests done without charge or for a charge which differs from the standard charge?

(8) Is any work done for the pathologist which he or she pays for personally? How is such work recorded on the logs.

(9) Does the hospital send tests to outside labs or utilize outside services?

(A) Determine the contractual and billing arrangements for such outside service.

(B) Who selects outside services to be used?

(C) Do departmental employees work for outside services, or for hospital physicians as well?

(b) Identify the person responsible for vendor selection and purchasing. Ask the person in charge of day-to-day operations for an opinion with respect to the quality and price of materials and services used in the department. What assurances are there that competitive prices are obtained?

(c) Determine ownership (by hospital or other party) of departmental equipment; obtain details of leases (e.g., from the hospital to the physician or from a third party to the hospital or physician), rentals, purchase options and service contracts.

(d) In concluding the interview, the auditor should inquire about problems existing in the department, knowledge of improprieties, and other matters that require explanation.

(e) The auditor should discuss the functions of the department with the pathologists to determine the details of the financial arrangements between the hospital and the physicians and the nature and extent of their practice in and outside the hospital. Items to be covered include: private practice, especially that conducted on hospital premises; the types and volume of procedures performed; billing practices; administrative duties, including service on hospital committees; involvement with purchasing equipment and supplies; and other matters that require disclosure and explanation.

Section 5.8.5 - Detailed Audit Procedures (Laboratory
Department)

(a) The log book should be examined in conjunction with the test of charges. The purpose of the review is to identify an abnormally large number of specific tests, the absence of certain tests, and the reasonableness of entries. Log book entries for patients selected in the charge test should be reconciled to charge slips, doctors' requests, medical records, and patient account cards. In addition, a sample of entries in the log book should be traced to patient billing records and the income journal to ascertain whether all procedures are being billed properly.

(b) The auditor should test the reasonableness of the compensation paid to the radiologist if based on percentage or related to volume, and the number of procedures and tests (statistics reported).

(c) A detailed review of purchases by this department should be made as follows:

(1) Review the general ledger accounts for the source and volume of purchases,

(2) Trace general ledger entries to sources (e.g., purchase journal) and review,

(3) Examine invoices, purchases orders, and receiving documents, as well as other evidentiary matter in support of original entries in the purchase journal or other book of original entry, on a test basis, and

(4) Schedule irregularities or discrepancies for further investigation.

Section 5.9 - Examples of Possible Fraudulent Practices
in Other Revenue Centers

The following are some types of frauds noted in certain other revenue centers, together with techniques designed to detect them. The examples are not to be considered all-inclusive, or in any way indicative of which revenue centers should be audited. Here again, the experience and judgment of the auditor, together with available information and audit results, will dictate the scope of the audit work to be done in each area.

Section 5.9.1 - Examples of Fraudulent Practices -
Operating Room

(a) Inflation of time when charges are based on time. Audit technique: compare charges per bill to pricing structure, medical records, operating room log and anesthesia records for selected patients.

(b) Alteration of procedural descriptions in order to obtain reimbursement for non-reimbursable services or a higher reimbursable service. Audit technique: Compare patient billing (claim forms) to operating room log and medical record.

(c) Charging for full surgical suite when emergency room or other facility was used. Audit technique: Compare patient billing record to operating room log.

Section 5.9.2 - Examples of Fraudulent Practices -
Anesthesiology

(a) Billing by anesthesiologist who is not present during procedure (nurse anesthetist administers anesthesia). Audit technique: compare patient charge per bill to operating room log for selected patients, note the presence of nurse anesthetist on operating room log and trace to see how patient was charged.

(b) Inflating anesthesia time billed. Audit technique: Compare bill with medical record, anesthesia record, operating room log, and recovery room log.

Section 5.9.3 - Examples of Fraudulent Practices -
Pharmacy

(a) Billing for drugs not administered. Audit technique: trace medication chart in patient's medical record to patient's bill.

(b) Improper handling of drug rebates. Audit technique: see Section 4.1 (Purchasing) and Section 4.2 (Vendor Audits).

(c) Inventory Thefts. Audit technique: comparison of usage of specific drugs per pharmacy distribution sheets to drug utilization per inventory control.

Section 5.9.4 - Examples of Fraudulent Practices -
Electrocardiography

(a) Billing Medicare patients at a higher rate than other patients in order to maximize Medicare settlement. Audit technique: trace EKG logs to patient bills for patients of differing financial classes.

Section 5.10 - Audit Guide for Provider-Based Physicians

Provider-based physicians are, according to HIM-15, §2108, those physicians other than interns and residents who provide services in the hospital setting and have financial arrangements under which they are reimbursed by or through a hospital. Provider-based physicians or hospital-based physicians ("HBP") can work in any service area, including radiology, pathology, anesthesiology, cardiology, and the emergency room. The services performed consist of two elements:

(a) Service to hospital (provider component): the administrative, teaching, and other hospital services (e.g., committee participation, research, supervision of personnel, utilization review) performed by the HBP is considered the provider component. The hospital is reimbursed for the reasonable cost of these services under Medicare-Part A and these costs are included on the cost report.

(b) Direct services to patients (professional component): the provision of services to individual patients is considered the professional component. Under Medicare, such services are reimbursed through Part B on the basis of reasonable charges. The costs associated with the professional component are excluded from the

Part A settlement. The Medicare cost report has annexed to it a schedule (Apportionment of Hospital-Based Physician Renumeration for Professional Service - Combined Billing) to indicate the portion of physician renumeration to be excluded from the cost settlement.

Section 5.10.1 - Provider-Based Physician Financial Arrangements

Compensation arrangements between the HBP and the provider take a variety of forms. Examples of the most frequent arrangements include:

- (a) Fixed salary,
- (b) Percentage of gross or net billings or value of procedures performed,
- (c) Fee-for-service, that is direct or indirect billing to patients for services rendered,
- (d) Combination method, usually involving a salary and some form of percentage,
- (e) Guaranteed standby fees for emergency room physicians where the physician bills patients separately (See HIM-15 Sec. 2109).

Contractual agreements between the hospital and the physician, including the financial and billing arrangements and the basis for apportioning the professional component for Medicare purposes, are required to be in writing and up-dated annually. These documents are supposed to be filed with the Medicare fiscal intermediary and the Part B carrier (see HIM-15, §2108).

Section 5.10.2 - Audit Objective - Provider-Based
Physician Financial Arrangements

The investigative auditor should determine that the net amounts actually paid to HBPs have been apportioned and reported correctly by providers. In addition, the auditor must be alert to situations where a hospital has included the expenses of HBP services in its costs for reimbursement purposes while the physician is billing separately (this could be double billing).

In reviewing ancillary service departments, the auditor should be alert to situations where HBPs are using hospital facilities to treat their own patients or private patients referred to them (referred ambulatory patients). The Medicare regulations provide that direct and indirect costs of providing services to nonprovider (i.e., private) patients must be identified and deducted from allowable costs for reimbursement purposes. Costs may be estimated for this purpose, but if costs are estimated, such costs cannot be less than the revenue received by the hospital (see HIM-15, §2108.10).

The auditor should determine to what extent the costs associated with services to nonprovider patients and other non-reimbursable costs should be offset against

reported costs. Clues to the existence of a private practice on hospital premises may be obtained through:

- (a) Interview with administration,
- (b) Interview with ancillary department physicians and personnel,
- (c) Review of the provider's cost report (HCFA-2552),
- (d) Review of special purpose funds maintained by the hospital to receive revenue generated by private practice, and
- (e) Review of physician contracts, and
- (f) On site observation of private offices.

Section 5.10.3 - Procedures for Auditing Provider-Based
Physician Financial Arrangements

(a) From the provider's cost report, list all HBPs together with their compensation, if available, for all years and compare the amounts for consistency.

(b) Obtain from the provider (or the fiscal intermediary) the contracts for HBP compensation and professional component determination.

(c) Check the calculation of remuneration paid to terms of the contracts and to department revenue and expense as appropriate and trace to payroll records (e.g., W-2, Form 1099). (Note: The cost of fringes for HBPs under percentage compensation arrangements should not be reported as hospital expenses on the cost report.)

(d) Determine whether rent paid by HBPs is offset against the appropriate departmental costs. Trace the rent from the agreements to the general ledger and the cost report, and document the findings. Consider the reasonableness of the rent paid to the hospital.

(e) Review departmental costs to ascertain whether services performed by outsiders have been deleted from billings used to calculate percentages for remuneration. (Note: billings by an outside laboratory should not be included in the calculation of the compensation to which an HBP is entitled under a percentage method.)

(f) Document any refund, rebate, or donation from HBPs recorded in any hospital fund or account. Ascertain whether such amounts have been used to reduce HBP costs. (Doctors have been found to rebate a portion of their billings from private practice conducted within the hospital, which sums were not offset against allowable costs.)

(g) Inquire as to the procedures followed for billing physician services. Communicate with Blue Cross, the fiscal intermediary, the Part B carrier, and the Medicaid fiscal agents, and review invoices if double billing is suspected.

PART VI : AUDIT GUIDES FOR BALANCE SHEET ACCOUNTS

Section 6 - Audit Guide for Property, Plant and Equipment

The advent of major technological change in the last two decades, coupled with government funding programs, has stimulated tremendous capital expenditure for land, new and remodeled building structures, diagnostic and treatment instruments, and related supporting facilities, machinery, and equipment. The auditor should be especially concerned with the acquisition and disposition of capital assets, the values assigned to them, the accounting recordkeeping, and the related internal control.

The auditor should study Chapter 1 of HIM-15 for the rules relating to capital assets and depreciation. Depreciation computations are discussed in Section 4.5.1. The audit of capital assets should be coordinated with the auditing of depreciation. Construction project costs are discussed in Section 6.2.

Section 6.1 - Internal Control (Property, Plant and Equipment)

The auditor should investigate, document, and evaluate the hospital's system of accounting and management controls over property, plant, and equipment. These controls can be classified by functions as follows:

- (a) Budget and planning,
- (b) Procurement,
- (c) Authorization for payment,
- (d) Valuation and recording,
- (e) Physical security,
- (f) Disposition, and
- (g) Internal capital work orders.

Section 6.1.1 - Examples of Sound Internal Control
(Property, Plant, and Equipment)

In evaluating internal control, the auditor should consider the following as sound control features:

(a) Preparation and use of capital budgets and plans which are periodically updated and approved by the governing board.

(b) Centralized purchasing procedures involving approvals by two or more executives, competitive bidding, and the issuance of purchase orders.

(c) Authorization for payment based on the presentation of approved and audited invoices, together with evidence of receipt and inspection and approved purchase orders.

(d) Written capitalization policies which adhere to the principles of HIM-15; documentation of the basis for recording if historical cost is not used.

(e) Policies and practices to ensure that assets are safeguarded and capable of being located and identified; this can be accomplished by means of plant subsidiary ledgers, periodic inventories, the strict use of property passes in order to control asset removal, and property transfer reports.

(f) Controls over asset dispositions, such as: requisite governing board approval for major sales or retirements, departmental reports of assets disposed of, the use of shipping reports to control asset movement.

(g) Prompt recording of asset dispositions in the accounting records.

(h) Internal capital work orders prepared by the plant operating department and approved by the administration; these work orders should be submitted to the accounting department for control and capitalization.

Section 6.1.2 - Examples of Fraudulent Practices -
(Property, Plant, and Equipment

(a) A 'surplus' parcel of improved real estate was sold to a board member for a nominal sum. The board member relieved the hospital of heavy maintenance costs associated with the surplus parcel. Investigation revealed that local tax assessors later valued the property at twenty times the nominal purchase price.

(b) An examination of title of a proprietary facility revealed a string of title transfers between relatives and controlled companies at increasingly higher prices. The motives behind the transactions were allegedly for financial and tax planning purposes, but reimbursement was also affected because depreciation for rate setting purposes was based on the latest price.

(c) Equipment purportedly acquired for patient care could not be sighted on a physical examination by auditors. Investigation revealed that it had been removed by doctors for use in their private practice offices.

(d) A review of leases revealed that building (fixed) equipment was being 'leased' from a related company owned by the operator/administrator and the builder. The construction contract required these items to be installed by the builder and were included in the price of construction.

(e) A facility faced with a sizable disallowance of routine costs because of a peer group ceiling began capitalizing routine maintenance expenses, which properly should have been written off in the current period.

(f) Officials of a facility set up a fictitious lease for assets which also had been purchased. Rents were paid out to a dummy company and siphoned off.

(g) Donated assets were recorded at an inflated fair market value in order to obtain additional depreciation reimbursement improperly.

Section 6.1.3 - Audit Procedures (Property, Plant,
and Equipment)

(a) Obtain detailed asset listing and analysis for the period under review, and examine for significant additions and deletions. Compare these to notes taken during the tour of the facility and the review of the workpapers of other auditors.

(b) Examine invoices and supporting documentation for major additions. Verify cost, price, and receipt of the items. Check to board minutes for authorization, price, and terms. Investigate further if shipping documents appear irregular, or where the dealer or lessor is little-known.

(c) Examine contracts and deeds for major purchases of real estate; if necessary, obtain title search to help to ascertain whether the purchase was arm's-length. Ascertain the identity of the previous owners back to 1965 (inception of Medicare/Medicaid) at least. Determine whether prior sales were arm's-length deals or merely trafficking in real estate to take advantage of Medicare/Medicaid cost reimbursement.

(d) Where assets have been replaced, determine the disposition and handling of the old assets.

(e) For donated assets, examine the calculation of the fair market value. If appraisals were used to value assets, check the methodology of the appraisal for reasonableness. Check the arithmetic accuracy. Investigate the appraiser if not known to the auditor.

(f) For assets disposed of, investigate the circumstances if material. To whom were the assets transferred? For what consideration? Determine if the consideration was reasonable by reference to appraisals and tax assessments. Review accounting treatment of the disposition to insure that it adheres to the principles of HIM-15, Chapter 1.

(g) Inquire whether all dispositions have been properly recorded. Review board minutes, internal reports, insurance correspondence, security office files, and miscellaneous cash receipts for evidence of unrecorded asset dispositions.

(h) Review capital work order projects during the period. Discuss with plant operations personnel the

extent of such activity. Ascertain whether the proper amounts of material, labor, and overhead have been transferred from operating expense and capitalized.

(i) Obtain schedules of major leases. Compare to cash disbursement records to verify inclusion of all significant items.

(j) Obtain and review copies of major leases. Outline the principal terms -- asset description, term, rent, renewal, and purchase or other options. Ascertain whether the transaction was prudent from a cost standpoint.

(k) Ascertain whether the hospital has properly accounted for significant leases. Are capital leases recorded as assets and liabilities? Often hospitals seek to expense such assets in order to obtain increased reimbursement. (For a discussion of lease capitalization, see Financial Accounting Standards Board, Statement No. 13 (for years after 1976), Accounting Principle Board Statement No. 5 (for years prior to 1976), and HIM-15, Chapter 1. Basically, a capital lease is one which transfers substantially all the benefits and risks of ownership to the lessee.)

(l) Inspect physically where practicable the assets, leased equipment and facilities, as well as significant purchased additions.

(m) Where necessary confirm the existence of leased assets directly with the manufacturer; include description and serial number in the request.

(n) Ascertain whether the hospital has a certificate of need for significant additions from the local health planning authority.

(o) For donated assets, inspect if practicable and investigate the methods used to value these. (The basis of depreciation of assets previously used or depreciated under Medicare/Medicaid is the lesser of fair market value or net book value in the hands of the owner last participating in the programs, see HIM-15, §114.2.) Review board minutes and correspondence to determine the circumstances surrounding the gift. Be alert to purchases of like items shortly before or after the gift since this could be evidence of a fraud or kickback (e.g., a vendor simultaneously sold one X-ray processing machine to a hospital and purportedly donated another. The second machine didn't exist but the hospital claimed depreciation for both.)

(p) Investigate inappropriate capitalization of items which could constitute personal expenses (e.g, snowmobiles, boats, stereo equipment, cameras).

Section 6.2 - Audit Guide for Construction Costs

(a) Audit Objective. Construction activity in the hospital industry is both extensive and ongoing in nature. Facilities are constantly being remodeled, modernized, and expanded. Hospital construction is a complex process involving expenditures running into millions of dollars.

Because state agencies and local health planning authorities are involved in hospital planning, financing, approval, and final certification of additions and improvements, the auditor must be acquainted with this process. Interviews with state officials and examination of official files should be conducted at the outset to trace the approval and certification processes. A special official audit of the construction account is usually performed, especially if public financing or guarantees are involved. The auditor should obtain the reports and workpapers relating to this audit, and inspect them for reliability, completeness, and areas of possible weakness.

The auditor's principal objectives in examining the construction costs of a facility are to detect and measure inflation of these costs as a result of kickbacks

to hospital personnel, bribes to government officials, conflicts of interest and self-dealing by hospital officials, the inclusion of non-approved costs, and the diversion of hospital assets.

(b) Cost Elements. The elements comprising total project costs are:

- (1) Land,
- (2) Construction contract including fixed building equipment (Class I),
- (3) Movable equipment (Class II),
- (4) Professional services,
- (5) Architect,
- (6) Legal,
- (7) Clerk of the Works,
- (8) Inspection - laboratory,
- (9) Test borings,
- (10) Monthly surveys,
- (11) Feasibility studies,
- (12) Consulting fees,
- (13) Carrying and finance costs,
- (14) Construction interest,
- (15) Fees (administrative - other),
- (16) Title insurance,
- (17) Administrative,

- (18) Management cost,
- (19) Accounting,
- (20) Insurance, and
- (21) Initial occupancy (sometimes reclassified as start-up).

Section 6.2.1 - Internal Control (Construction)

Because the construction project originates within the hospital, the auditor should start there to investigate and document the administrative and accounting controls which existed at the time the project was conceived. It would normally be beyond the capabilities of an administrator to continue to run the day-to-day operations of a hospital and, in addition, take on the task of managing a large construction job. Therefore, the hospital will designate or hire a Project Manager, usually an engineer.

The following are examples of sound internal control to be considered:

(a) Competitive bidding by contractors and suppliers, documentation of bids and explanation of exceptions; formal approval and acceptance.

(b) Selection of independent architect; architectural approval of contractors' requisitions.

(c) Use of fixed price as opposed to cost-plus contracts.

(d) Architect and board approval of change orders.

(e) Employment of Clerk of the Works to perform on-site check of time worked, materials in place, and other functions.

(f) Effective use of construction cost budgeting and time schedules.

(g) A system of authorization for payments requiring documentation of approvals by the Architect, Clerk of the Works, and the Project Manager.

Section 6.2.2 - Examples of Fraudulent Practices (Construction)

(a) Land - (i) land purchased from a related entity at an inflated price, (ii) land donated and recorded at an inflated value, and (iii) land acquired and not needed for the project.

(b) Construction contracts - (i) bidding rigged, no documentation of bids received, (ii) undisclosed relationships between contractors and sub-contractors and hospital officials, (iii) equipment specified in the plans was omitted or cheaper equipment substituted, (iv) kickbacks to hospital officials, (v) overstatement of costs by contractors, and (vi) payment for unapproved construction and for non-existent change orders (extras).

(c) Equipment - (i) equipment billed but never delivered to hospital (kickback paid to hospital employee), (ii) equipment cost marked up to cover kickbacks (iii) substitution of cheap equipment, (iv) overstatement of amounts paid by the hospital, and (v) equipment diverted to private use.

(d) Professional fees - (i) fees paid to relatives and associates or to professional (e.g., law, accounting, architect) firms in which public officials have an

interest, (ii) bribes masked as payments to professionals, (iii) payments for services not performed or not related to the project (e.g., litigation, lobbying, personal services for hospital officials).

(e) Carrying and finance costs - (i) capitalization of costs related to excess borrowing, (ii) failure to offset income on idle funds, and (iii) fees paid to relatives and associates for services not rendered.

(f) Administrative expenses - (i) capitalization of fictitious items, (ii) shifting excess operating costs to construction account to avoid ceiling disallowance, and (iii) inclusion of personal expenses (e.g., travel and entertainment) in construction costs.

(g) Cost overruns - this may be evidence of a scheme involving deliberate underbidding by favored contractors who were assured of change orders to meet their price and terms.

(h) Insurance and initial occupancy costs - capitalizing fictitious or personal item costs.

Section 6.2.3 - Procedures for Auditing Construction
Costs

(a) Obtain records of the state agency, lender and the facility, and compare cost breakdowns. Note and investigate any discrepancies, such as reversals of decisions, or variations in cost approved vis-a-vis final cost.

(b) Review state agency project files and audit agency files (if any), and compile listings of firms, officials, persons responsible for the project and any other pertinent information.

(c) Obtain land title history and plot map. Ascertain and investigate any relationship to parties in interest, use of site, and reasonableness of the acquisition cost. If appraisals were used, they should be obtained and evaluated.

(d) Investigate the award of the construction contract to the contractors. Examine the contract and all amendments, and review the circumstances of change orders. Examine checks paid and tie in to total contract cost. Compile listing of major subcontractors and suppliers for background investigation. Ascertain the

costs and profits to the general contractor by reviewing the contractor's books and records. If necessary in the auditor's judgment, a full audit of the general contractor and individual subcontractors should be made, especially if bid or other irregularities have been detected.

(e) Obtain lists of approved equipment. Compare to invoices. Determine if competitive bids were obtained. Inspect for selected equipment items. Confirm prices and delivery with original manufacturers where a broker exists.

(f) Review architect's contract. Compare amount and rate of fee to AIA standards and state authorities. The architect should be interviewed if the fee is being divided, or if it seems excessive, or if there are cost overruns, and to resolve questions regarding the bidding and awarding of contracts. An audit of the architect's books and records should be made, if the circumstances warrant.

(g) Review the attorney's retainer agreement. Investigate the attorney's connections, especially if the fee appears to be excessive in relation to time and effort expended. Interview the attorney to determine the

scope of the services performed and their appropriateness. An audit of the law firm's books and records should be considered if the circumstances warrant.

(h) Inspect payments to the Clerk of the Works. Perform background check. Interview to determine the existence of irregularities on the job and records maintained.

(i) Scrutinize relationships with consultants by inspection of cancelled checks and contracts, interviews and, if warranted, audits of financial records.

(j) Verify that the amount of construction interest has been calculated and charged to the project correctly. The auditor should review the use of loan proceeds. Determine that the cut-off dates for the capitalization of interest are accurate. Income from temporary investment of construction funds should reduce interest costs.

(k) Financing and other fees, if not paid to a public agency, should be reviewed for propriety.

(l) Obtain or prepare an analysis of what is included in administrative costs. Vouch to corroborating evidence (e.g., paid invoices, payrolls). Determine the reasonableness of allocation of construction costs.

(m) Analyze amounts of all other costs; if significant, investigate their nature. Obtain documentation supporting validity and relation to construction purpose.

(n) Reconcile total costs per audit to provider's total costs.

Section 6.3 - Audit Guide for Investments

In general, investments and idle cash are often held by hospitals in various funds. These funds are established to provide separate accountability or stewardship over specific assets. Examples of such funds are the "Unrestricted General Fund" or "Operating Fund" (including so-called "Board Designated Funds"), and restricted funds such as "Endowment Fund," and "Specific Purpose Fund" and "Plant Replacement Fund." Fraud and abuse in the area of investments generally involves either embezzlement and conversion of principal or income, or misrepresentation of investments and investment income in order to avoid offsetting such income against interest expense claimed for reimbursement.

A material theft of hospital assets causes economic hardship to the facility, disrupts the delivery of quality patient care, and leads to increased Medicare/Medicaid program costs (e.g., by necessitating additional borrowing). Investments, therefore, are an area of concern to the investigative auditor.

Section 6.3.1 - Internal Control (Investments)

The auditor should document and evaluate the hospital's control over this specific area. In addition to the general management controls, the auditor should ascertain the existence and effectiveness of the following sound internal control procedures:

(a) Use of an investment committee (responsible to the board) which authorizes investment transactions and reviews investments and use of idle cash,

(b) Use of a reputable independent custodian, such as a trust company or bank, as a depository for hospital funds,

(c) Use of bank safe deposit vaults with controls over access when a custodian is not used to hold securities,

(d) Separate investment records and ledgers, and

(e) Periodic reporting of investment position to management.

Section 6.3.2 - Examples of Fraudulent Practices (Investments)

(a) Employee theft of investment fund, principal, and interest income.

(b) Control of fund by undisclosed related party (e.g., a board member causing funds to be deposited in a non-interest or low interest bearing account in a financial institution controlled by the member).

(c) Attempting to obtain third-party reimbursement for costs of acquiring and maintaining investment funds (e.g, fund raising, custodial, or advisory expenses).

(d) Recording excess cash or other assets attributable to related parties as an investment on the books of the hospital. In a proprietary hospital, this can result in inflated equity thereby increasing equity reimbursement.

(e) Improper recording of interest expense for borrowed investment principal (e.g., the building fund borrows money and the interest is charged to the operating fund).

Section 6.3.3 - Procedures for Auditing Investments

(a) Review other auditors' workpapers for this area. Determine if the condition of the internal control and the extent and reliability of the audit work necessitate any further auditing in this area.

(b) If necessary, review the hospital's records of investments and related income. Trace additions and dispositions to source documents: board and committee minutes, bank or broker advices, custodian statements. All large dispositions should be accounted for.

(c) Test the arithmetic accuracy of the records.

(d) Compare large donations in cash or property from the investment records to underlying documents, such as donor's correspondence and board minutes. Ascertain whether the correct fund was credited with the gift (e.g., unrestricted gifts are placed in the unrestricted fund; restricted gifts are put into a building, endowment, or other special purpose fund).

(e) Determine whether all investments were counted or otherwise confirmed as of the audit date. If not, question management about this and investigate the item further.

(f) Schedule and investigate interfund transfers during the period. Determine what effect, if any, these had on reimbursement (e.g., if bonds held in an unrestricted fund were transferred to the building fund, was this necessary or done merely to avoid the offset of income against interest cost?) Note: if funds derived from gifts and grants are commingled with other funds, the income from such investments must be used to offset allowable interest expense (HIM-15, Chap. 2).

(g) Compare investment income to prior year amounts and to the expected yield of the portfolio. Note and investigate any discrepancies.

(h) Ascertain whether all investment income has been properly recorded in each respective fund. Likewise, determine whether expenses, such as custodial fees and administrative costs, are allocated properly.

Section 6.4 - Audit Guide for Other Balance Sheet Accounts

In order to verify the hospital's statement of reimbursable costs, the investigative auditor must be concerned primarily with the statement of revenue and expenses and the underlying accounts. Nevertheless, the balance sheet accounts must not be overlooked, since these accounts generally interact with the operating statement (e.g., deferred charges and accrued expenses). In the case of a theft of assets, the result of the crime may be evident in asset accounts which upon examination indicate the assets represented are missing, fictitious, or worthless.

The auditor must also be alert to irregularities in liabilities and fund balances. Long outstanding accounts payable and accruals which are never paid or reversed may be indicative of an inflation of costs. Also, fund balances may be used to conceal income offsets.

Section 6.4.1 - Cash on Hand and in Banks

Thefts of cash may not have an immediate impact on reimbursement, though such thefts can be costly to an institution because they affect liquidity and cash flow, among other things. Review and testing of the controls and recordkeeping for cash were covered in the sections on the Revenue and Expenditure Cycles (Secs. IV and V).

Section 6.4.1.1 - Internal Control (Cash)

The following are examples of sound internal control of cash:

(a) Cashing checks from cash receipts is prohibited. If not prohibited, it is strictly controlled.

(b) Cashiers are prevented from gaining access to patient billing records and the general ledger.

(c) Deposits go directly from the cashier to the bank. Security is maintained.

(d) The person opening mail prepares a list of checks. This list is sent to accounting and compared to the deposit slip.

(e) Receipts for cash are numbered. These are accounted for daily. Receipts must be issued for all over-the-counter payments.

(f) Cash registers are used. Tapes are audited and retained.

(g) Bank accounts are reconciled promptly and reviewed by a responsible official.

(h) Check endorsements are compared to payee.

(i) Check numbers are accounted for.

(j) Deposits in transit are dated as to clearing on bank reconciliations.

(k) Bank transfers require two signatures.

(l) The governing board has not delegated authority to establish banking accounts to any individual.

(m) Cash funds are on an imprest basis.

(n) The person responsible for cash funds is independent of other custodial or control functions. There is a signed receipt for the fund.

(o) Reimbursement checks are made payable to the custodian of the funds.

(p) There is a current list of all petty cash funds.

(q) Cashing checks from petty cash is prohibited.

(r) There is a maximum dollar amount on petty cash disbursements.

(s) Proper authorized vouchers for petty cash are submitted and effectively cancelled.

Section 6.4.1.2 - Examples of Fraudulent Practices
(Cash)

(a) Unrecorded income from an outpatient clinic laboratory was concealed by hospital officials and stolen. Checks received from this laboratory were substituted for cash received by the inpatient laboratory and pocketed by the director of finance. The scheme flourished because of the failure to maintain independent records of the revenue in the outpatient department, the diversion of cash directly from the department to a highly placed member of management, as well as collusion among management personnel.

(b) An officer was given authority by the board to open bank accounts. Subsequently, the officer began transferring cash from gifts to accounts he controlled and siphoning off the funds.

(c) For additional examples of fraudulent practices, see the Revenue and Expenditure Cycles (Part IV and Part V).

Section 6.4.1.3 - Procedures for Auditing Cash

(a) Review the work of other auditors, especially the independent accountants for the hospital. In most cases, the work done previously will be extensive and if judged to be reliable will reduce the amount of further auditing. Be sure to look for evidence of exceptions and weak areas noted by other auditors, and investigate these as necessary.

(b) Review the practices of the hospital in transferring cash between funds. Note whether checks made payable to another fund are charged to a 'due to' or 'due from' account or directly to a fund balance. Note whether expense charges are duplicated as a result of exchanging such checks.

(c) With respect to bank balances and interbank transfers:

(1) Obtain bank statements, reconciliations, and passbooks for all bank accounts which the institution may have.

(2) Review the bank reconcilliations noting any unusual reconciling items;

(3) Ensure that the balance per books as shown on the bank reconciliation is, in fact, the true general ledger balance;

(4) Note all interbank transfers of cash; and

(5) Determine the purpose for such transfers.

Section 6.4.2 - Inventories

Inventories of hospital supplies include food and dietary supplies, pharmaceuticals, medical/surgical supplies, spare parts, housekeeping supplies, office supplies, and building maintenance supplies. The volume of activity in these areas accounts for approximately 12 to 15 percent of total costs; however, many individuals in management and accounting do not consider these items material in relation to the overall assets and consequently do not give sufficient attention to controls or inventory taking.

The investigative auditor should examine carefully management's policies with respect to inventory control, together with the accounting records maintained. Serious deficiencies or irregularities in the control of inventories and their valuation for cost reporting purposes should be investigated. Aside from the problem of pilferage by employees and vendors, there is a risk of hidden (unrecorded) inventories which will overstate the related expenses on the cost report and thereby increase reimbursement.

Section 6.4.2.1 - Internal Control (Inventories)

Internal control over the requisition, procurement, receipt, and payment for goods was discussed in Part IV, Expenditure Cycle-Purchases. These controls form the basis for the system of inventory control. Essentially, inventories are controlled either by a perpetual or periodic inventory system in which book values are adjusted to physical quantities.

Examples of sound internal control practices are:

(a) There are in existence specific policies concerning inventory control and these policies are enforced.

(b) Designated individuals are accountable for the receipt of goods and supplies.

(c) Security measures to prevent removal of goods from the premises are in existence and enforced.

(d) Storerooms are locked and access controlled.

(e) Storerooms are orderly with goods arranged by product and type.

(f) Storekeepers are required to inspect incoming goods and issue receiving reports to the accounting department.

(g) Signed requisitions for ordering and withdrawing goods from inventory are used.

(h) Inventories are taken at least once a year.

(i) Perpetual inventories are adjusted to physical.

(j) Inventory adjustments are recorded on the general ledger.

(k) Inventory adjustments are reported to management.

(l) Inventories purchased and stored off-premises (such as in a warehouse) are recorded, accounted for, and are secure.

Section 6.4.2.2 - Procedures for Auditing Inventories

(a) Review other auditors' workpapers, especially those of the independent accountant for the hospital. Be sure to read the independent accountant's management letter comments on inventories. Ascertain whether any adjustments to inventory were proposed and why. Also review consistency of pricing from year to year.

(b) Review the provider's costs reports and financial statements for inventory quantities for the years under review. Note any wide fluctuations and investigate. Trace the cost report figures to the general ledger; review any activity in the ledger.

(c) Review the statistical comparison of departments affected by inventories (see Sec. 3.3). Ascertain if the cost per patient day (or similar unit) is fluctuating in a manner that cannot be explained by inflation.

(d) Determine whether the quantity of inventory at year-end is consistent and can be correlated to the volume of purchases as reflected in the general ledger for each respective department (e.g., dietary, pharmacy, plant operation, housekeeping).

(e) Schedule all significant exceptions noted during the inventory review and apply extended audit procedures as necessary.

Section 6.4.3 - Other Assets

Other assets, including prepaid expenses and deferred charges, should be reviewed for the nature of their content and activity. Other auditors may have spent considerable time on other asset balance sheet accounts which should reduce the necessity for further work.

'Loans and exchange' or 'suspense' accounts, where used, should be examined closely. It has been found in many audits that these accounts were used to divert rebates, refunds, and other monies improperly.

Section 6.4.4 - Liabilities

The investigative auditor should review the content of liability accounts to ascertain their nature and the transactions giving rise to the account. Other auditors should have performed extensive work on liabilities to ensure that they were recorded correctly. This work should be reviewed.

The following points should also be covered:

(a) Does the hospital prepare aged trial balances of accounts payable and do they agree with the general ledger?

(b) Does the age of the accounts appear about the same for all vendors? Are some favored?

(c) Are patients' credit balances significant? Why?

(d) Are other liabilities backed up by subsidiary controls? Are accrued liabilities documented, reasonable; are they paid within a specified time?

(e) Are interfund liabilities/receivables in balance? Cleared periodically?

(f) Are there loans from related parties? Why? In proprietary establishments this can sometimes be the result of fraudulent transactions, such as purchases of overvalued assets. These transactions should be investigated.

(g) Are long-term debts separately noted and disclosed in the financial reports. Are these items related to patient care?

(h) Is deferred income recorded? Is this proper?

Section 6.4.5 - Fund Balances

Fund balances have from time to time been the burying ground for all sorts of curious entries. The investigative auditor should examine these accounts carefully. The examinations should be coordinated with the review of all funds -- restricted, endowment, and other special purpose funds.

The independent accountant may have performed detailed audits of fund balances and certified a combined statement of changes in fund balances in the hospital's annual financial report. This work should be reviewed carefully.

Section 6.4.6 - Restricted Funds

Fund accounting, as applied in not-for-profit hospitals, is defined as the process of accounting for economic resources in independent sets of self-balancing accounts. Funds are segregated by purpose, activity, or legal restrictions. According to the American Institute of Certified Public Accountants' Hospital Audit Guide, such accounting is compatible with generally accepted accounting principles.

Funds are either unrestricted or restricted. Unrestricted funds are all resources which may be used in the day-to-day operation of the hospital as the governing board determines. Restricted or special purpose funds are those subject to legal restrictions by third parties such as donors or government agencies. Examples of restricted funds are:

(a) Specific Purpose Funds including Grants (Temporary Funds). Gifts, grants, and bequests which are restricted by third parties or donors to some specific activity should be combined under Specific Purpose Funds. Many accountants are of the opinion that all special activity costs should be accounted for in designated cost centers in the operating (unrestricted) fund. Portions of specific funds should then be transferred and offset

against such related costs (e.g., gifts or grants stipulated for the support of a delivery room would be used to reduce such related operating costs in the cost finding rate setting process.) The auditor should consult the Medicare/Medicaid and Blue Cross regulations for rules governing offset of restricted funds in specific areas.

(b) Endowment Funds. These funds are set up upon receipt of gifts or bequests with restrictions over the use of principal or income. They are either permanent or term endowments, the latter usually indicating that the restriction expires after a period of time.

(c) Plant Replacement and Expansion Funds. These funds sometimes include money paid to the hospital as reimbursement by third-party payors in addition to gifts and grants for this purpose. These funds can be used only to replace fixed assets or to upgrade the plant. Transfer should be made from the operating (unrestricted) fund for that portion of the depreciation required to be funded.

The audit objectives in this area are to determine whether the restricted funds are being used for their intended purposes, that controls are in place to prevent thefts and misappropriations, and that reimbursable costs have not been overstated by such practices as failing to offset revenue against applicable operating costs, or by shifting assets or revenues from unrestricted to restricted funds.

Section 6.4.6.1 - Examples of Fraudulent Practices
(Restricted Funds)

(a) Surplus funds were transferred to the building fund by the operating fund and re-invested. Had they remained in the operating fund, the income would have been used to reduce interest expense.

(b) Direct costs of operating non-reimbursable departments were paid out of specific purpose funds and not reported on the cost report. As a result, no allocations of hospital overhead expenses to the non-reimbursable areas were made.

(c) A special purpose fund was found to have been abused by hospital personnel who, because of ineffectual controls, were able to charge personal expenses to the fund and withdraw money with little or no accountability for its use.

(d) Crediting a restricted fund with refunds and other income when these should be offset against operating expenses of the unrestricted fund.

(e) Crediting unrestricted gifts to restricted funds, and vice versa.

(f) Writing off uncashed checks issued by the hospital to unrestricted or restricted fund balances.

Section 6.4.6.2 - Procedures for Auditing Restricted
Funds

(a) Examine the provider's cost reports and financial statements for the years under examination. Note and compare the activity in restricted funds.

(b) Obtain from the hospital the controlling document, deed, or grant that contains the conditions under which the fund is to be used. Judgment should be used in determining the size or number of funds to be examined. Should a hospital be unable to produce documentary evidence for a restriction, the fund may really be a discretionary one and, if commingled, investment income should be used to reduce allowable interest expense.

(c) Review cash receipts and cash disbursements of the restricted funds on a test basis. Determine whether funds are classified properly and are used for a proper purpose. Ascertain whether internal controls are effective in this area.

(d) Scan the activity passing through the 'due to' and 'due from' other fund accounts. Ascertain if such activity is proper by analysis of the nature of the transactions.

(e) Examine the fund balance accounts. Be alert to transfers of assets in or out; these should be investigated to determine the motive and the reimbursement impact.

(f) Coordinate the review of restricted funds with the review of investments (Sec. 6.3).

(g) Ascertain whether transfers to the operating (unrestricted) fund for reimbursement of specific activities are based on a reasonable determination of costs. Trace such transfers to the cost report to ensure that they are properly reported. Ascertain whether all transfers have been properly booked.

PART VII - AUDIT GUIDE FOR OPERATING STATISTICS

Section 7 - Overview

Operating statistics include all reported quantitative measurements of service, productivity and operations of the hospital, other than the financial statements. Operating statistics and their reliability are essential to the analysis of operating results and to cost accounting. Statistics can be ranked in importance as follows:

(a) Those statistics which become a factor in the rate calculation (e.g., patient days, visits, discharges) and have a direct impact on reimbursement.

(b) Statistics utilized in cost finding or cost allocation which indirectly impact on the reimbursement rates (e.g., square feet, number of meals served, pounds of laundry distributed).

(c) There is a third group of statistics whose purpose and function is informational. These data amplify the other statistics and enable interested parties to analyze and interpret the productivity, cost performance, and financial operation of the hospital.

There has been a lack of uniformity and standard definitions of functional cost-center statistics in the hospital industry. Divergence in methods of compiling statistics and the lack of standard units of measurement have made it difficult to compare a hospital's performance from one period to another, and also to other hospitals in a similar group.

The emergence of the System for Hospital Uniform Reporting (SHUR) which was mandated by the Medicare and Medicaid Anti-Fraud and Abuse Amendments (PL 95-142) is a significant step towards greater accountability by hospitals. Among other things, one of the purposes of SHUR is "to provide a common standard of measurement and communication through the use of uniform... statistical and service data definitions." (Draft SHUR Manual, August 4, 1978, page 0.2).

The investigative auditor should limit the examination to establishing the reasonableness and consistency of a particular set of statistics as opposed to a 100 percent verification of them. Detailed analyses or reconstruction of a set of statistics would generally be limited to cases where a material misrepresentation or alteration in statistics was uncovered and such audit workpapers were needed as evidence that a fraud had been committed.

Section 7.1 - Reimbursement Rate Setting Statistics

Section 7.1.1 - Audit Objectives

Because these measurements are used directly as a factor or component in the calculation of reimbursement, it is essential that their accuracy be verified.

The principal statistics in this group are:

- (a) Number of beds,
- (b) Patient days (medical/surgical, pediatrics, maternity),
- (c) Admissions,
- (d) Discharges,
- (e) Emergency room visits,
- (f) Clinic visits, and
- (g) Referred ambulatory visits.

Section 7.1.2 - Internal Control

The system and the controls over the capturing of statistics were covered in the Section on the Revenue Cycle. The auditor should review and consider the findings resulting from the work in that area.

Section 7.1.3 - Examples of Fraud and Abuse (Reimbursement
Rate Setting Statistics)

(a) Understatement of bed complement to avoid penalties such as that for low occupancy.

(b) Understatement of patient days to increase the amount of per diem costs or reimbursement (e.g., total cost divided by patient days equals per diem cost), and to avoid length of stay penalty.

(c) Overstating discharge data to avoid length of stay penalties (e.g., length of stay equals patient days divided by discharges).

Section 7.1.4 - Audit Procedures (Reimbursement Rate
Setting Statistics)

(a) Review comparative schedules of statistics for the years under examination. This data should have been accumulated as a result of work done in Preliminary Research - Target Selection (Section 2.2.1 of the Manual. Note significant variations for further investigation.

(b) Review the audit work on statistics performed by the hospital's auditors, Blue Cross, and the Medicare intermediary. If the amount of work of prior auditors is deemed to be extensive and reliable, the auditor should limit the scope of the audit accordingly.

(c) Compare the reported bed complement to the operating license issued by the local government authority. The auditor should be alert to understatements of bed complement which would be done to avoid a low occupancy penalty. Any indication of beds in excess of the authorized number should also be noted and investigated.

(d) For patient days, admissions, and discharges, trace the data from the cost report to the hospital's census summary.

(e) Obtain the monthly census reports and prepare a summary analysis with column listings for opening census, admissions, discharges, one day stays, and closing census. Foot and cross foot the monthly reports. Reconcile the analysis to the hospital's census summary.

(f) Select a representative test month (or months) and trace the data in (e) above to the daily census sheets and to the nurses' floor counts.

(g) Review charge test workpapers (Section 5.2.2) for patient admission and discharge information. Tie in the admissions and discharge data to the respective daily census report or buildup.

(h) Ascertain whether independent or dual patient day statistical accumulations exists such as in the medical records department, admitting department, business or billing office. Compare these records and note discrepancies for investigation.

(i) Determine the statistical relationship between the occupancy level and gross revenue - routine inpatient services by comparing each month's recorded patient days with each month's gross charges. Note and investigate any unusual discrepancies.

(j) For emergency room, clinic, and ambulatory visits, trace the number reported to the hospital's summary. Foot the summary and trace the details to each respective department's log or register.

(k) Emergency and outpatient department logs or registers should have been examined in the course of the audit work on revenue departments, the revenue cycle and the test of charges. If necessary, summarize the entries in each specific log. Reconcile the totals to the monthly and year-to-date summary for these revenue centers.

(l) Prepare a schedule of adjustments to reported patient days, admissions, discharges, emergency room, and outpatient visits, together with a narrative description of the auditor's procedures and conclusion.

Section 7.2 - Cost Finding Statistics

This group of statistics comprise the statistical bases of allocation used to determine the cost of each general and special service department. The audit objective is to verify the accuracy of the statistics used and their consistency between periods.

Space limitations prohibit listing of all possible types of statistics in this group. The auditor should consult the Medicare, Medicaid, and Blue Cross regulations to ascertain the recommended bases or statistics to be used.

Some examples are:

<u>Statistic</u>	<u>Cost to be allocated</u>
Square feet	Depreciation - buildings, fixed and movable equipment
Square feet	Maintenance and operation of plant
Pounds or pieces of laundry	Laundry and linen
Meals served	Cafeteria/Dietary
Number of employees	Maintenance of personnel
Number of procedures	X-ray; lab tests

The auditor must also consider statistics used in expense reclassification prior to cost finding. These are equally as important as those used for cost finding.

Section 7.2.1 - Examples of Fraud and Abuse (Cost
Finding Statistics)

(a) Costs can be allocated from a low or non-reimbursable cost center to a higher reimbursable cost center. As in the case of depreciation of buildings, square footage of clinic areas and emergency rooms might intentionally be combined with the square footage of an inpatient cost center. This would in effect allow the depreciation expense to be allocated entirely to the inpatient side which will be reimbursed at a higher rate.

(b) Costs can be allocated out of cost centers where ceiling limitations apply and be transferred to cost centers which are not subject to such ceilings. If a hospital has a ceiling limitation on its emergency room, house physicians assigned to this area could intentionally be assigned to an inpatient cost center. This would benefit the hospital in that physicians' salaries would not be subject to the emergency room ceiling limitation and would be reimbursable as an inpatient expense

(c) Non-reimbursable cost center statistics may be omitted from the cost finding formula resulting in under-allocation of expenses to non-reimbursable cost centers; in the case of a non-reimbursable cost center, the square footage and other cost-finding statistics could be intentionally included in an inpatient cost center where it would be reimbursed, rather than in a non-reimbursable cost center where the costs would be eliminated through the cost finding formula.

Section 7.2.2 - Audit Procedures (Cost Finding Statistics)

(a) Determine which statistics are used in cost finding and cost reclassification. List and compare between periods for consistency. Also compare the statistics to other similar statistics in the cost report for consistency. Note unusual patterns or discrepancies.

(b) Review other auditors' workpapers for the extent and reliability of their work on statistics. Based on this review, the auditor should decide on the scope of the examination. Before substantial additional work is scheduled, a study of the reimbursement impact and the probability that a significant discrepancy exists should be done.

(c) Review the work done on Preliminary Research - Target Selection (Section 2.2.1) and Review of Cost Reporting (Part III) above. For exceptions noted, review and discuss with appropriate department head and personnel responsible. Determine causes for the exceptions noted and decide whether further investigation is necessary.

(d) Review the backup support for statistical compilation and methodology used by the hospital. Trace to the source document used for posting to the compilation. Note any exceptions. For example, test the square footage to official blueprints or engineers' measurements of the building.

(e) Test the mathematical accuracy of the compilations.

Section 7.3 - Statistics for Informational Purposes

All other statistics included in the cost report and supplemental reports should be reviewed for the purpose of determining discrepancies such as illogical relationships and inconsistencies. Instances where this is so may lead to the discovery of falsification of statistics for the purpose of shifting costs.

Another purpose of analyzing informational statistics is to detect abnormal patterns of operations or costs between periods and between one hospital and a similar group of hospitals. These procedures were previously described in Section 2 of the Manual (Preliminary Research - Target Selection).

PART VIII : FINDINGS AND DOCUMENTATION

Section 8 - Workpapers

Audit workpapers are normally kept as evidence of the work done in support of the auditor's opinion. In a fraud audit, workpapers do not only document the auditor's work, but may constitute admissible evidence as well. The auditor's workpapers are used as evidence in grand jury and trial proceedings and in civil recovery actions. In many jurisdictions, the workpapers would be subject to discovery and inspection and the auditor could be examined with respect to any matter related to them. Often the trial will be conducted months or even years after the initial field work has been performed. Auditors who worked on a particular case may no longer be available, or the memories of those available may not be adequate; resulting in re-doing much audit work to ensure that the auditor's testimony and evidence will be beyond reproach. This duplication of effort can be avoided if the workpapers are initially prepared in an orderly and logical fashion, well documented and carefully reviewed.

Audit programs typically call for many steps which do not require the use of worksheets and such steps might not be represented in the work papers. (Examples of these steps

are the review of the intermediary's work papers, tour of the hospital, and review of internal control.) In order to avoid this, all such steps should be documented by memoranda and included in the workpapers.

The audit programs used should be included with each section of the workpapers, with references to the schedules where the work indicated was performed. A memorandum should be placed at the front of each workpaper section, indicating specifically what area has been reviewed (e.g., patient statistics, accounts receivable, test of charges). The memorandum should include a thorough description of the hospital's accounting system for the area, a detailed description of what the objective of the review was, how the review was performed, and what the results were. The workpapers should contain sufficient evidentiary matter to support each memorandum. Flowcharts should be used when necessary to explain or clarify the subject.

All workpapers should be indexed, signed, dated, and should include headings indicating the hospital being audited, the year audited, the area reviewed (e.g., accounts receivable, payroll) and the source of the data (e.g., general ledger, purchase journal, medical

records). All work performed on schedules should be documented by tickmarks with adequate explanations.

Workpapers should be arranged in a standard order by the investigative agency to facilitate location of documents, the exchange of information between cases, and workpaper review. An auditor not familiar with a given case should be able to find information contained in the workpapers of that case with relative ease. Audit reports, grand jury presentations, and other work should be referenced to the workpapers. Such items should be reviewed by someone of at least senior status and not connected with that case, to ensure that all items are properly prepared, documented and cross-referenced. The following is an outline of a workpaper format that has been found to be adequate.

Workpapers generally will consist of three files:

- (1) General file - recurring items of a general nature,
- (2) Report file - reports of hospitals and third parties, and
- (3) Workpapers.

General File

The general file should contain all items of a general nature. These include:

- (1) Index to the file,
- (2) Inventory of records received,
- (3) Audit program,
- (4) Summary time control,
- (5) Time sheets for each auditor,
- (6) Chart of accounts,
- (7) Hospital statistics,
- (8) Organization chart,
- (9) Internal control flowchart of operating procedures,
- (10) Hospital questionnaire,
- (11) Major vendor list,

- (12) Minutes of meetings,
- (13) Correspondence,
- (14) Internal audit reports,
- (15) Memos and investigator's reports,
- (16) Leases and contracts,
- (17) Real property information,
- (18) Comparative analysis file (cost reports, et
cet.), and
- (19) Reimbursement review.

Report File

This file should contain the hospital and third-party reports, including:

- (1) Hospital reports:
 - (a) Cost reports, and
 - (b) Budget

(2) Independent certified public accountant's reports:

- (a) Financial statements,
- (b) Workpapers,
- (c) Permanent file, and
- (d) Correspondence file.

(3) Intermediary:

- (a) Work papers,
- (b) Permanent file,
- (c) Correspondence file,
- (d) Desk review,
- (e) Rate file,
- (f) Appeals,
- (g) Step-downs,
- (h) Rate computation sheets,
- (i) Financial settlements, and
- (j) Supplemental reports.

Workpapers

A set of workpapers should be prepared for each year audited. It should include all audit workpapers and memoranda obtained or prepared. Since the audit work

will be modified depending on the circumstances in each case, individual index schedules should be prepared and placed on top of each file.

A suggested index system follows:

<u>Workpaper No.</u>	<u>Name</u>	<u>Description</u>
1	Index Sheet	
2	Audit Report	Cross-indexed draft of audit report.
3	Summary of Findings	Accumulation sheet for audit findings and adjustments cross referenced to the work papers.
4	Inventory of Records	Control listing of records requested, received, and returned by the auditor.
10	Trial Balance- Journal Entries	Copies of provider trial balances, journal entries and related audit papers. See sections on Audit Planning and Control and Reimbursement.

<u>Workpaper No.</u>	<u>Name</u>	<u>Description</u>
20	Examination of Disbursements	Workpapers relating to examination of checks, invoices, and cash controls. See Expenditure Cycle.
30	Review of Vendors	Workpapers relating to accounts payable and vendor activity. See Expenditure Cycle.
40	Audit of Expenses	Workpapers relating to examination of direct departmental costs and general costs. See Expenditure Cycle.
50	Payroll Audit	Workpapers relating to review of payroll. See Expenditure Cycle-Payroll.
60	Audit of Statistics	Testing and analyses of reported statistics.

<u>Workpaper No.</u>	<u>Name</u>	<u>Description</u>
70	Audit of Operating Revenue	Test of charges, audit work on cash receipts, and detailed testing of revenue centers. See Revenue Cycle.
80	Allowances, Bad Debts	Audit work relating to deductions from revenue. See Revenue Cycle.
90	Audit of Other Revenue, Expenses	Audit work performed on other operating and non-operating revenues and expenses.
100	Audit of Special Funds	Audit work relating to donor restricted funds. See Restricted Funds.
110	Audit of Related Organizations Costs	Audit work relating to costs from related organizations.

<u>Workpaper No.</u>	<u>Name</u>	<u>Description</u>
A.	Property, Plant, and Equipment	Audit papers relating to acquisition costs, related depreciation, and leases. See Property, Plant, and Equipment.
B.	Investments	Audit papers relating to investments and related income - all funds.
C.	Loans and Exchanges (Suspense Accounts)	Audit papers reflecting examination of activity in these accounts.
D.	Other Assets	Papers pertaining to prepaid expenses, inventories. See section on Other Balance Sheet Accounts.
AA.	Restricted Funds	Analyses of fund activity, interfund transfers. See Restricted Funds.

<u>Workpaper No.</u>	<u>Name</u>	<u>Description</u>
BB.	Current Liabilities	Audit papers relating to accruals and other liabilities.
CC.	Long-term Liabilities	Analysis, documents relating to long term debt and related interest expense.
DD.	Capital Accounts (for profit)	Analyses of contributed capital, withdrawals, owners loans, et cet.
EE.	Fund Balances (not-for- profit)	Analyses of activity and changes in funds and related audit documentation.

Section 8.1 - Evidence and Findings

Ultimately, in the course of any investigation where fraud is uncovered, the auditor will be called upon to testify as to how the audit was conducted and what the findings were. It is essential that the auditor know precisely how the audit findings moved from the alleged fraudulent transaction to the ultimate third-party reimbursement. This not only includes tracing the items through the books and records of the facility to the cost report, but also includes verifying any reimbursement rates calculated based on inflated or otherwise improper cost reports, tracing bills submitted by the hospital to the applicable fiscal agency, and verifying payment of those bills to ascertain that the third-party payor was, in fact, damaged by the fraud.

Often fraudulent items will not have any third-party reimbursement impact. Among the reasons for this are:

(a) The item was originally charged to owner's drawing account or some other non-reimbursable account.

(b) The item was reclassified at year end to drawing or some other non-reimbursable account.

(c) The item was eliminated during a desk review of the cost report.

(d) The rate calculated by the normal methodology was never implemented. This could happen if:

(1) The facility closed before being reimbursed.

(2) The facility changed ownership and the new owner negotiated a new rate based on budgeted or projected costs.

(3) A new rate was imposed by court order as a result of litigation regarding the rate setting methodology, bankruptcy, or other reasons.

(4) Where rates are determined prospectively, a major change in operations (such as the addition of a new wing or the opening of a new building) resulted in a new rate based on some projection of costs, rather than on actual historical costs.

(e) Costs were disallowed because of ceilings. Where ceilings are imposed, the hospital may not be reimbursed for 100 percent of its costs. Ceilings may be related to specific types of expenditures, such as

administrative salaries, or they may be general in nature such as the Medicare ceiling on routine inpatient care. Where general or overall ceilings are involved, it has always been the position of the New York State Medicaid Fraud Control Unit that Medicaid larceny exists only to the extent that the dollar value of fraudulent items exceed the aggregate value of ceiling cuts. The reasoning behind this is that if the fraudulent items not in excess of a facility's ceiling cuts were removed from the cost report, and a new rate calculated, the new rate would not be any lower than the old one; therefore, Medicaid was not defrauded.

This position on Medicaid larceny is not the only possible one. Although it is not known to have been tested in a case, the position can be taken that Medicaid larceny results even when the aggregate costs disallowed by general ceiling cuts exceeded the dollar value of the fraudulent items. The concept here is that the cuts were not specifically identified as pertaining to any particular costs, but applied proportionately to each dollar of cost submitted for reimbursement. For example, a cost report included \$100,000 in fraudulent costs subsequently had \$200,000 in ceiling cuts. If \$200,000 represents 10% of all costs, then only \$10,000 of the

fraudulent item (10% of \$100,000) was disallowed. Accordingly, 90% of the fraudulent items were included in reimbursable costs.

Regardless of the method used to measure the impact of fraud on third-party reimbursement, the inclusion of fraudulent items on a cost report may constitute a criminal offense (e.g., filing a false or misleading instrument) depending on state or federal law. In jurisdictions where peer group ceilings are based on unaudited figures, the inclusion of fraudulent items will have the effect of raising the peer group cost averages and thereby affect reimbursement and ceiling cuts for all hospitals in the group.

If the fraudulent item did in fact impact on the Medicaid reimbursement rate, it may have had an impact on Medicare, Blue Cross, and on other third party payors. The impact on each third-party payor should be separately determined.

The auditor may have findings which do not impact on Medicaid, Medicare, or other third-party reimbursement. Embezzlement and theft losses are expected to be covered by insurance and for this reason usually are not allowable costs for Medicare and Medicaid.

Evidence of crimes such as embezzlement, theft, and others such as tax fraud, if uncovered, should be brought to the attention of the attorney-in-charge for proper disposition. The quality of the workpapers and supporting documentation should be equal for all classes of findings.

Section 8.2 - Testimony

Prior to testifying the auditors should review their findings with the attorney who will be questioning them in the grand jury. They should be sure that their workpapers contain the information that will be needed and that this information can be located quickly and easily. A lead schedule containing a summary of all findings, with appropriate cross-references into the workpapers is recommended.

The auditor should critically review the workpapers. They should also be reviewed by an auditor who did not work on that particular audit. This review should include tracing all postings through the workpapers, making sure that:

- (1) All cross references are correct.
- (2) All operations performed (such as footing, crossfooting, tracing, et cet., are indicated by tickmarks, footnotes, and other appropriate notations.
- (3) That the audit trail is complete, that is, that the fraudulent transaction has been traced from inception through to actual reimbursement to the facility.

During grand jury testimony, meticulous workpaper preparation will pay off. Memory cannot be relied upon, and a review of well-organized and well-documented workpapers will enable the auditor to handle questions from the attorney as well as from jurors. Occasionally, despite the best preparation, a question may be asked of the auditor for which the answer is not at hand, either because it is not in the workpapers or because it cannot readily be located. The auditor should not try to compute the answer while on the stand, nor fumble through the workpapers. The auditor should simply state that the answer is not on hand, but can be worked up or located later. The attorney can then excuse the auditor from the witness stand and the auditor can leave the stand and prepare the answer in private.

Personal appearance is extremely important in testifying before a grand jury. The auditor will usually testify less than an hour, and perhaps for only a few minutes. This is not really enough time for a group of jurors to assess capabilities. Much of the grand jury's evaluation of the auditor as an expert witness will depend on the image projected to the jury and on how well the auditor communicates while testifying and answering questions.

Personal appearance is important. Articles of clothing, jewelry, which could tend to be distracting should be avoided. In addition to attention to personal appearance, the auditor should maintain a professional manner while testifying. This is best accomplished by following the advice given earlier, namely, preparing the questions and responses with the attorney, reviewing workpapers, and avoiding fumbling around needlessly on the stand making computations or trying to locate items in the workpapers.

The auditor should work closely with the attorney and the investigator in deciding what oral testimony and documentary evidence will be required of other witnesses and deponents. Testimony and evidence regarding cost report preparation and submission, rate calculations, billing and payment, will be required. The auditor should be certain that the attorney understands the entire reimbursement mechanism, and the auditor should advise the attorney as to what function each governmental agency or department and third-party payor performs, so that the attorney will know what evidence is required from these units. The auditor should assist the attorney in preparing witnesses for the grand jury, making certain that the witnesses understand the case as it pertains to their role or function. The auditor should also review

any calculations made by other agencies before they are introduced into evidence. If the auditor is not entirely satisfied with the methodology or clerical accuracy of any rate recalculations, this should be explained in detail to the attorney.

If possible, the auditor should review the testimony of expert witnesses to make sure that their testimony is technically correct, and to make sure that the court reporter has transcribed all of the testimony correctly. Terms that might not be familiar to a court reporter should be called to the attention of the attorney-in-charge of the case promptly; a list of these terms can be given to the court reporter as an aid to preparing an accurate transcript of testimony.

Appendix

VENDOR BACKGROUND - QUESTIONNAIRE

Hospital Name:

Vendor's Name:

Vendor List Page: _____

Address:

Telephone:

A/K/A:

Principal/s' Name:

Category of Merchandise:

Serviced Hospital From:
 (Dates) From:

To:

To:

Salesman's Name:

Address:

Telephone:

DOLLAR VOLUME:

1973

1974

1975

1976

Vendor Background Questionnaire

Method of Shipping: Drop Ship ☐ _____ %
(Percent of each) Outside
Trucker ☐ _____ %

Company
Trucks ☐ _____ %

Other ☐ _____ %

Deliver Days: (Percent of Total Number of Deliveries)

Scattered

Sunday

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Test Periods: (For delivery day percentage above)

From/To: 1.

2.

Hospital Employee Signing Delivery Ticket or Invoice:

Name: _____

Department Using Merchandise

Interview suggested:

☐ Yes ☐ No

Vendor Background Questionnaire

Auditor's Name: _____

Comments:

Investigator's Name: _____

Comments:

GLOSSARY OF RELEVANT TERMS

In the following section those terms relevant to auditing a hospital and to the understanding of the hospital as an organizational entity are briefly described. The definitions provided are offered to give a frame of reference to the auditor who will encounter a wide variety of terms in auditing a hospital. These terms which may be largely unfamiliar to the auditor are often without a single, uniform definition or definitions may vary depending on the context used.

The definitions included in the following section have been adapted and can be supplemented from a variety of sources including:

American Hospital Association(AHA)

-Uniform Hospital Definitions

-Chart of Accounts for Hospitals

American Institute of Certified Public Accountants(AICPA)
Hospital Audit Guide

American Medical Record Association(AMRA)
Glossary of Hospital Terms

Commerce Clearing House (CCH)
Medicare and Medicaid Guide

Department of Health, Education, and Welfare (DHEW)
Medicare Provider Reimbursement
Manual (HIM-15)

Health Care Financing Administration (HCFA)
System for Hospital Uniform Reporting (SHUR)

Joint Commission on the Accreditation of
Hospitals (JCAH); Accreditation Manual
for Hospitals

State Health Codes

Subcommittee on Health and the Environment of the
Committee on Interstate and Foreign
Commerce. U.S. House of Representatives -
A Discursive Dictionary of Health Care

Abuse

Improper or excessive use of program benefits, resources, or services by either providers or consumers. Abuse can occur, intentionally or unintentionally, when services are used which are excessive or unnecessary, which are not the appropriate treatment for the patient's condition, when cheaper treatment would be as effective, when billing or charging does not conform to requirements, or as a result of filing of false or misleading cost reports. Abuse should be distinguished from fraud, in which deliberate deceit is used by providers or consumers to obtain payment for services which were not actually delivered or received, or claim program eligibility. Abuse is not necessarily either intentional or illegal.

Accrual

The financial effects of transactions and other events on the assets and liabilities of an entity are recorded and reported in the time periods to which they relate as opposed to when cash is actually received or disbursed. Estimates and informed judgement must often be used to assign dollar values to the effects of transactions and events in order to measure the impact on the entity.

Allowance - Charity

The difference between the full charge and the amount received or receivable from indigent patients.

Allowance - Contractual

The difference between the amount of the full charge and the amount to be paid by third parties (Blue Cross, Medicare, Medicaid, etc.) based on agreement.

Allowance - Courtesy

Discounts from the full charge granted to employees, clergy, or others having special relationships to the hospital.

Ancillary Service

An organized unit of a hospital with facilities and personnel to aid physicians in the diagnosis and treatment of patients through the performance of diagnostic or therapeutic procedures. Ancillary services may include delivery room, operating room, anesthesiology, laboratory, blood bank, radiology, and respiratory, physical, speech, and occupational therapy.

Definitions of ancillary services vary to some degree based on the source used. In this Manual, the Medicare Guide definition which considers ancillary services as those services for which separate charges are customarily made has been used. Other definitions may not define ancillary services on the same basis and, as such, may not include operating room or delivery room which can be considered as nursing services.

Audit Scope

The extent or range to which the auditor applied examining procedures. This can refer to both the types of procedures employed or to the types of accounts audited.

Ambulatory Services

Services provided on an outpatient basis. These services include clinic, emergency, and other comparable services.

Average Length of Stay (ALOS)

Theoretically, the number of patient days associated with all discharges and deaths divided by the number of discharges and deaths. However, the number of patient days of care during a given period divided by the number of discharges and deaths in that time period is more often used.

Bad Debts

The balance of the hospital full charge attributed to uncollectibility. This is not to be confused with allowances.

Bed Complement

The number of beds as it appears on the operating certificate issued by the state licensing agency. Generally this excludes beds in the emergency, anesthesia, and recovery rooms and beds used for special diagnostic procedures.

Board Designated Funds

Unrestricted funds (resources) set aside by the hospital's Board for specific uses.

Ceilings and Ceiling Disallowances

Based on comparison with similar institutions, the costs per day of a hospital may exceed those in its peer group by some excess amount (e.g., average cost plus 25 percent). Based on Medicare or Medicaid regulations, for example, these excess costs may not be allowed for reimbursement. The maximum allowable amount (in this case average peer group cost plus 25 percent) is considered a ceiling. All costs over that are ceiling disallowances.

Clinic and Clinic Patients

A clinic is a hospital unit which provides diagnostic and therapeutic services on a non-emergency basis to ambulatory patients. Clinics are often divided into subspecialties based on physician and surgical services of the hospital. The large teaching hospitals will generally have more clinics, whereas in small community hospitals there may be very few or no clinic services.

Co-insurance

A provision in third party contracts whereby the patient is personally responsible for a specified percentage of the costs and charges for covered services.

Coordination of Benefits (COB)

Provisions and procedures used by third parties to avoid duplicate payment for coverage insured under more than one plan.

Coronary Care Unit (CCU)

An intensive care unit specially equipped to provide constant care to patients with heart problems or those who have had heart or heart related surgery.

Cost Allocation Bases

The cost finding process involves the assignment of costs from non-revenue departments and ancillary departments to routine cost centers based on statistical or other bases. These are called a cost allocation bases.

Cost Center

An accounting device whereby all costs attributable to an organizational unit or activity (e.g., housekeeping, dietary, outpatient clinics) are accumulated and segregated for accounting or reimbursement purposes.

Cost Finding

The apportionment or allocation of the costs of non-revenue producing cost centers to each other and to revenue producing cost centers on the basis of statistical or other data that measure the amount of services rendered by each cost center to other centers.

Cost Report

Report filed at least annually which serves as the basis for cost finding, and determining reimbursable costs and rates. For Medicare this report is usually made on Form HCFA 2552 - Hospital and Skilled Nursing Facility Complex Statement of Reimbursable Cost.

Discharge Patient Days

The total number of patient days rendered to persons discharged in a given time period.

Emergency Room

An area of the hospital designed to serve those patients who require rapid treatment to sustain life or prevent critical consequences.

Fiscal Intermediary

The agent, usually an insurance carrier, acting on behalf of the government in determining the Medicare Part A reimbursement settlement for hospitals and skilled nursing facilities.

Fraud

Intentional misrepresentation by either providers or consumers to obtain services, payment for services, or to claim program eligibility. Fraud may include the receipt of services which are obtained through deliberate misrepresentation of need or eligibility, providing false information concerning costs or conditions to obtain reimbursement or certification, or claiming payment for services which were never delivered or received. Fraud is illegal and carries a penalty when proven. See also abuse.

Full Time Equivalent (FTE) Employee

The total number of worked hours divided by the standard work time equals the number of full time equivalents, i.e., 2 employees each work 50 hours in one week and the standard work week is 40 hours:

$$\text{FTE} = \frac{2 \times 50}{40} = \frac{100}{40} = 2.5 \text{ FTE}$$

In essence, these two employees did the equivalent work of 2.5 employees.

General Services

Often referred to as the "hotel type" services provided within the hospital, these services involve dietary, plant operation and maintenance, housekeeping, and laundry and linen.

Hospital Based Physician

Those physicians who provide services in a hospital setting and have financial arrangements under which they are compensated by or through a hospital.

Intensive Care Unit (ICU)

A specialized nursing care unit designed and equipped to serve the needs of those patients who need constant care and attention.

Internal Control

The plan of organization and all the coordinate methods and measures adopted within a hospital to safeguard its assets, check the accuracy and reliability of its accounting data, promote operational efficiency and encourage adherence to prescribed managerial policies.

Joint Commission on the Accreditation of Hospitals

A private, non-profit organization whose purpose is to establish and encourage high standards of medical care. Based on a review of the hospital by medical examiners, an accreditation status is granted (full, provisional, or none). Hospitals must be accredited to participate in the Medicare program.

Non-reimbursable Cost Center

A cost center whose direct and indirect operating expenses are not recognized by third parties as includable in determining reimbursement rates. Examples are the costs associated with doing research, seeing private patients, or running a gift shop.

Non-revenue Cost Centers

Support or overhead units, such as dietary services, that provide necessary services to other hospital departments. Other examples are personnel, housekeeping, and laundry and linen.

Occupancy Rate

The ratio of actual patient days (determined by patient census) to available bed days (determined by certified bed capacity.)

Operating Statistics

All reported quantitative measurements of service, productivity, and operations of the hospital other than the financial statements.

Patient Day

The unit of measure denoting lodging facilities provided, and services rendered, to one patient between the hospital census taking hours on two successive days.

Patient Mix

By Pay Class

Patient Mix refers to the financial class of the patients treated. For example, a hospital may have 5% Medicaid, 10% Medicare, 40% Blue Cross, and 45% other third parties and self-pay patients in a given fiscal period.

By Diagnosis

A description of the hospitals workload identified by

diagnosis. The mix of cases directly affects such factors as length of stay, intensity, scope and cost of services provided.

Per Diem Rate

A common method of reimbursement, which represents a fixed payment to the provider regardless of the intensity of service rendered based upon an average cost calculation per day.

Professional Component

Physician services which are directly related to the care of individual private patients. These services are reimbursed by Medicare under Part B.

Professional Standards Review Organization (P.S.R.O.)

Not-for-profit organizations mandated by the 1972 Amendments to the Social Security Act (PL 92-603). PSRO's are established by the Secretary of Health, Education, and Welfare in designated area and consist of local licensed physicians.

Among other things the PSRO is responsible for assuring by ongoing reviews that payments under Medicare, Medicaid, and Maternal and Child Health Programs are only made (1) when medically necessary, (2) for services meeting appropriate professional standards, and (3) in case of inpatient care, for an appropriate level of care and length of stay (duration).

Proprietary Hospital

A privately owned medical facility operated for profit.

Prospective Reimbursement

A method of reimbursement whereby the rate of payment for services rendered by a provider is fixed in advance of a particular fiscal period; the rate is not adjusted subsequently to reflect the provider's actual costs of rendering those services. Blue Cross and Medicaid employ prospective reimbursement in New York State.

Provider Reimbursement Manual (HIM-15)

A manual of interpretations of Medicare cost and reimbursement rules and regulations, (contained in Health Insurance Regulations - HIRM-1), which are also applicable to the Medicaid program.

Ratio of Charges to Charges Applied to Costs (RCCAC)

Under the departmental method Medicare reimburses or settles ancillary service costs on the basis of the Ratio of Medicare Charges to all Charges Applied to all Costs. Example: Operating Room (OR) Medicare charges are \$10,000; total OR charges are \$80,000; total OR costs are \$64,000. The Medicare settlement therefore would be:

$$\frac{\$10,000}{\$80,000} \times \$64,000 = \$8,000.$$

Reclassification of Expenses

When the expenses of two or more cost centers used for cost finding purposes are accounted for in a single departmental account, the expenses should be segregated for more accurate cost finding. The process of identifying and segregating these expenses is known as the reclassification of expenses.

Recovery of Expense

Certain hospital departments generate revenue not related to patient care (e.g., Medical Records sells abstracts, Laboratories provide, and bill other providers for lab tests, the Cafeteria generates income, etc.). These revenues should be offset on the cost report against the expenses associated with the providing such services to determine the costs relating to patient care.

Referred Ambulatory Patient

An outpatient who uses only special diagnostic or therapeutic facilities or services of a hospital upon referral by a physician. Upon completion of the special

tests or treatments, the patient is referred back to a physician for further care. The term is exclusive of clinical or emergency patients.

Restricted Fund(s)

Funds restricted by donors or grantors to specific uses, such as, Specific Purpose and Endowment Funds.

Retrospective Reimbursement

Determination of the amount or rate of reimbursement after the conclusion of the fiscal period and upon the filing of a statement of reimbursable cost. Medicare reimburses on a retrospective cost basis.

Revenue Producing Cost Centers

Hospital departments providing direct services to patients and thereby generating revenue. Examples are: Radiology, Physical Therapy, Inhalation Therapy, and Laboratory.

Routine Costs

Cost of providing hotel type services including linens, housekeeping, room and board also called General Service Costs.

Silver Recovery or Silver Reclamation

The processes associated with developing X-ray films leave silver in the liquid. This silver along with scrap and used film can and should be reclaimed and sold with the resulting revenue offset against the expenses of the department.

Special Care Unit

A unit designed and equiped to meet the needs of patients requiring specialized attention and care. Examples are:

- ICU Intensive Care Unit
- CCU Coronary Care Unit
- PCU Progressive Care Unit
- HSU Heart Surgical Unit.

Staff Privileges

The privilege, granted by the hospital, to a physician or other practitioner to join the medical staff and admit private patients. Privileges are usually granted after certain standards are met and upon commitment to perform duties for the hospital such as teaching or working in the clinic without pay. (Staff privileges are only extended to a limited number of physicians, as a rule, which in turn gives rise to charges of discrimination and at times litigation.)

Physicians may only have the privilege to admit their private patients (admitting physician) or may be legally responsible for the care given a patient while hospitalized (attending physician).

Standard Unit of Measure

An attempt to measure the productivity of different departments by defining the parameters of the service provided. For example, a Laundry and Linen Department could be measured by the number of clean and dry pounds of laundry processed; a Laboratory by the relative value units of the procedures performed; the Dietary Department by the number of patient-meals served.

Step Down

A method of cost finding employed by third party payors by which all expenses incurred by hospital providers are allocated to each functional cost center.

Teaching Hospital

A hospital which provides undergraduate or graduate medical education for physicians usually with one or more medical, dental, or osteopathic programs approved by a professional body. These programs are referred to as internship or residency and are conducted in affiliation with medical schools. Merely offering nursing education, continuing education, or in-service training is not sufficient to be classified as a Teaching Hospital.

Teaching Physician

A physician who has responsibilities for training and supervising interns and residents. Often teaching physicians are full time salaried physicians rendering professional services to patients. (See Hospital Based Physicians.)

Third Party Payors

This refers to private and public insurance plans that pay part or all of the cost of health care for their beneficiaries. Payment may be to the provider of the beneficiary. Examples include Blue Cross, Travelers Insurance, Worker Compensation, Union Health and Welfare Funds, Medicaid, and Medicare.

Tissue Committee

A hospital Committee that evaluates all surgery by the process of comparing pre-operative, post-operative and pathological diagnoses to the procedures undertaken. Tissue removed during surgery is examined and evaluated by the pathologist, hence the name. Tissue Committees are intended to minimize unnecessary surgery.

Title XVIII

The Federal Social Security Act which contains the legislative authority for the Medicare program.

Title XIX

The Federal Social Security Act which contains the legislative authority for the Medicaid program.

Uniform Financial Report (UFR)

Annual financial report filed in New York State (along with supplements for Blue Cross, Medicaid, and Medicare) to initiate the cost finding and rate setting process.

Unrestricted Fund

Funds from sources not restricting their usage. These funds can be utilized at the discretion of the hospital board.

Visits

An outpatient "occasion of service." Each patient seen in each clinic is one visit. Some third parties will count a visit as each time a patient appears for services regardless of how many clinics are visited.

Voluntary Hospital

A non-profit, non-governmental hospital. Most non-federal hospitals are organized on a voluntary basis.

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Health Care Financing Grants and Contracts Reports

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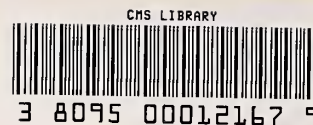
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